83-2136

IN THE

Supreme Court of the United States

October Term, 1983

No. 84-

STATE OF CONNECTICUT, DEPARTMENT OF INCOME MAINTENANCE,
Petitioner,

v.

MARGARET M. HECKLER, SECRETARY, AND THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

DONALD M. LONGLEY
Assistant Attorney General
90 Brainard Road
Hartford, Connecticut 06114

CHARLES A. MILLER*
MICHAEL A. ROTH
Covington & Burling
1201 Pennsylvania Avenue, N.W.
P.O. Box 7566
Washington, D.C. 20044
(202) 662-6000

Attorneys for Petitioner State of Connecticut, Department of Income Maintenance

*Counsel of Record

June 1984

16 pp

QUESTION PRESENTED

Whether a limitation in the Medicaid law on use of federal funds to reimburse states for the care of patients in "institutions for mental diseases" should be confined to traditional mental hospitals or should be extended to cover newly developed "intermediate care facilities" that serve residents with mental conditions calling for a lesser level of custodial care.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

IN THE

Supreme Court of the United States

October Term, 1983

No. 84-

STATE OF CONNECTICUT, DEPARTMENT OF INCOME MAINTENANCE,
Petitioner,

v.

MARGARET M. HECKLER, SECRETARY, AND THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

Petitioner ("Connecticut") petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Second Circuit is reported at 731 F.2d 1052 and appears as Appendix A, pp. 1a-16a. The opinion of the United States District Court for the District of Connecticut is reported at 557 F. Supp. 1077 and appears as Appendix C, pp. 1c-25c. The opinion of the Departmental Grant Appeals Board of the United States Department of Health and Human Services ("DHHS") is unreported and appears as Appendix D, pp. 1d-61d.

JURISDICTION

The judgment of the Court of Appeals was entered on March 30, 1984. App. B, p. 1b. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The following are provisions of the Social Security Act, Title XIX (Grants to States for Medical Assistance Programs), Pub. L. No. 89-97, § 121, 79 Stat. 343-353 (1965) (as amended):

1. Section 1905(a) of the Act, 42 U.S.C. § 1396d(a)(1), (4)(A), (14), (15) and (18)(B), as amended, provides in relevant part:

> "(a) The term 'medical assistance' means payment of part or all of the cost of the following care and services . . .
>
> (1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);
>
> • • •
>
> (4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older; . . .
>
> • • •
>
> (14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;
>
> (15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined . . . to be in need of such care;

> • • •
>
> (18) . . .; except as otherwise provided in paragraph (16), such term does not include . . . (B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases."

2. Section 1905(c) of the Act, 42 U.S.C. § 1396d(c), as amended, provides in relevant part:

> "(c) For purposes of this subchapter the term 'intermediate care facility' means an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities . . . . The term 'intermediate care facility' also includes any skilled nursing facility or hospital which meets the requirements of the preceding sentence . . . . With respect to services furnished to individuals under age 65, the term 'intermediate care facility' shall not include, except as provided in subsection (d) of this section, any public institution or distinct part thereof for mental diseases or mental defects."

The provisions with respect to intermediate care facilities were added by section 4(a) of the Social Security Amendments of 1971, Pub. L. No. 92-223, 85 Stat. 809.

STATEMENT

This case presents an important and recurring question of interpretation of the statute establishing the Medicaid program that has been decided against DHHS by four federal courts, but was decided in favor of DHHS by the court below. That

decision is in square conflict with the decision of the Court of Appeals for the Eighth Circuit in *Minnesota* v. *Heckler*, 718 F.2d 852 (1983) (Appendix E hereto).

The question is what Congress meant in using the term "institution for mental diseases" in defining the kinds of health-related services covered by the Medicaid program. The dispute turns on whether this term was meant to cover only facilities providing the level and intensity of care that is characteristic of mental hospitals, as held by the Eighth Circuit court, or, as the Second Circuit court held, embraces as well intermediate care facilities ("ICFs"), which provide a much less intensive level of care and have been developed to treat persons with mental conditions but for whom the level of care provided by mental hospitals is inappropriate and unnecessary.

The case arises as a result of actions taken by an agency of DHHS to "disallow" federal funding for services provided to residents in certain ICFs in the States of Connecticut, Minnesota and Illinois, and certain skilled nursing facilities ("SNFs") in California. The disallowances were upheld in a single consolidated decision by the Departmental Grant Appeals Board, a body within DHHS established by the Secretary to resolve disallowance disputes. The Board's decision was appealed separately by each of the affected states. The Minnesota disallowance was set aside by the District Court for the District of Minnesota [1] and that decision was upheld by the Eighth Circuit Court of Appeals (Appendix E). The Illinois disallowance was set aside by the District Court for the Northern District of Illinois in *Illinois* v. *United States Department of Health and Human Services*, No. 82-C-1349 (March 20, 1984) (Appendix F). The Connecticut disallowance was also set aside by the District Court for the District of Connecticut (557 F. Supp. 1077) (Appendix C). However, that decision was reversed and the disallowance reinstated by the court below.[2]

[1] Minnesota v. Schweiker, No. 4-82-155 (D. Minn. August 25, 1982).

[2] No decision has yet been rendered in the suit brought by California to challenge the Grant Appeals Board decision.

The origins of the Connecticut dispute and the history of the litigation below can be summarized as follows:

The Medicaid program, established in 1965, makes federal funds available to the states to share in the costs of medical care provided to needy eligible individuals, to the extent covered by an approved State Plan. The original statute excluded from federal financial participation services provided to patients under age 65 in institutions for mental diseases ("IMDs"). 42 U.S.C. § 1396d(a)(18)(B). It permitted coverage for institutional services for persons 65 and over in IMDs only on the condition that the state undertake programs to develop broader options for dealing with the problems of the mentally ill, including use of nursing facilities and other less intensive alternatives to IMDs. 42 U.S.C. § 1396a(a)(20) and (21); S. Rep. No. 404, Pt. I, 89th Cong., 1st Sess. 145-46 (1965). The term IMD was not defined in the statute.

In 1971, Congress brought ICF services under the coverage of the Medicaid program. 42 U.S.C. § 1396d(a)(15). An ICF was defined as an institution that provides medical assistance to individuals who because of their mental or physical condition require health care and services, but who do not require the degree of care and treatment that a hospital or skilled nursing facility provide. 42 U.S.C. § 1396d(c).

Since October 1974, Connecticut has included intermediate care facility services in its State Medicaid Plan. Jt. App. 55-56.[3] The facility in question in this case, Middletown Haven Rest Home, is an ICF that began operating as a duly certified Medicaid provider in 1977.[4] Connecticut received federal funds under the Medicaid program for services provided to eligible residents of Middletown Haven from 1977 through 1980. App. A, p. 4a.

[3] "Jt. App." refers to the Joint Appendix containing the record before the Court of Appeals.

[4] Connecticut has a number of public mental hospitals and private psychiatric hospitals that are concededly IMDs. Jt. App. 53-54.

In December 1979, an audit conducted by DHHS found that most of the residents of Middletown Haven had mental diagnoses and concluded that Middletown Haven should be classified as an IMD, and therefore precluded from federal sharing in the cost of any services rendered to residents at the facility. The audit conclusions were based on criteria that looked only to the diagnoses of the residents of the facility under review, and not to the nature of the care provided to the residents, in determining whether the facility was an IMD. Jt. App. 12-21.[5]

In September 1980, Connecticut received a notice of disallowance in the amount of $1,634,655, which represented federal financial participation payments that previously had been made to Connecticut for services provided to residents of Middletown Haven during the period 1977 through 1979.[6] Connecticut sought administrative review of the disallowance before the Grant Appeals Board. This action was consolidated with similar disallowances affecting three other states. The Board's decision upholding the disallowances led to the judicial proceedings summarized above, including the decision of the Court of Appeals for the Second Circuit reversing the District Court and upholding the disallowance.

Jurisdiction of the courts below was conferred by 28 U.S.C. § 1331 based on a right of action provided by the Administrative Procedure Act, 5 U.S.C. § 704. Both courts found that the District Court possessed jurisdiction. App. A, p. 7a; App. C, pp. 2c-3c.

---

[5] The criteria were never formally published but were set forth in instructions issued to field staff. *See* App. D, pp. 26d-28d. The only published material is a regulation providing that whether a facility is an IMD depends on "its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases." 42 C.F.R. § 435.1009(e).

[6] The disallowance was not predicated in any way on the quality of service provided at Middletown Haven. The responsible DHHS official described Middletown Haven as an "excellent facility" and an "ideal ICF." Jt. App. 76.

REASONS FOR GRANTING THE WRIT

Certiorari is warranted because the decision below squarely conflicts with the decision of another Court of Appeals reviewing the same administrative action, because the decision rests on a construction of the term "institution for mental diseases" as used in the Medicaid law that is inconsistent with this Court's prior expressed understanding of the provision, and because of the general importance and recurring nature of the issue presented. Resolution of the conflict over the meaning of the statutory term will determine the scope of Medicaid coverage of services developed to meet the Congressional objective, which was the creation of new kinds of facilities for people suffering some mental illness but who do not need the costly and intensive care provided by IMDs.[7]

A. Federal Courts Are In Conflict On The Important Issue Of The Scope Of The IMD Provision Of The Medicaid Law.

The major issue addressed by the Grant Appeals Board and in the judicial review actions brought by the affected states was whether the limitation on Medicaid coverage for services in IMDs extends to nursing and intermediate care facilities. Because of DHHS' view that any custodial facility participating in the Medicaid program could be an IMD, DHHS criteria for applying the IMD proviso did not consider the nature of the services provided by the facility. Thus, in applying the IMD provision, DHHS drew no distinction between mental hospitals and facilities providing lower levels of care, notwithstanding the extension of the Medicaid program in 1971 to ICFs, defined in the statute as facilities for persons requiring care because of their mental (or physical) condition.

---

[7] *See* Section 1902(a)(20) and (21) of the Social Security Act, 42 U.S.C. § 1396a(a)(20) and (21), enacted as part of the original Medicaid law in 1965, Pub. L. No. 89-97, § 121, 79 Stat. 347 (1965).

The Court of Appeals for the Eighth Circuit, relying upon the language and legislative history of the statute, rejected DHHS' views that the definition of IMD turned essentially on the diagnosis of the residents and that there was no distinction between mental hospitals and ICFs for IMD purposes. The court found the meaning of the term IMD to turn on the nature of the services rendered by the facility, and distinguished between the level of care required for patients in IMDs and the level of care offered in ICFs. App. E, pp. 17e-18e, 22e-23e.

A similar interpretation of the statute was adopted by the District Court in the Illinois case (App. F, p. 3f) and by the District Court in this case (App. C, pp. 20c-21c). However, the Second Circuit Court of Appeals expressly rejected the analysis of the Eighth Circuit court (App. A, p. 6a n.4) and instead accepted DHHS' view of the statutory term.

The Second Circuit court's holding in this case stems from a misunderstanding of the statute and its legislative history. The court acknowledged that there was logic to the State's construction of the statute, particularly its reliance on the extension of Medicaid to ICFs, which were created to serve people whose mental or physical condition required custodial care, albeit of a less intensive nature than is characteristic of mental institutions. The court's election of the DHHS view as "more plausible" was based on an incorrect notion, not advanced below by DHHS, that the State's view would arbitrarily distinguish between free-standing ICFs and those that were part of a mental hospital. App. A, pp. 8a-9a.[8] Each of the other federal courts analyzed the words of the Medicaid law and reached a conclusion opposite to that of the court below on the meaning of the IMD limitation.

[8] The court's decision leads to the truly arbitrary result that Medicaid coverage is available for some ICFs that care for people with mental conditions but not others, depending on whether the ICF is classified as an IMD under the agency's subjective criteria.

Likewise, the court below erred in its legislative history analysis by relying on certain statements at Congressional hearings by witnesses who were seeking outright elimination of the IMD provision (App. A, pp. 12a-14a),[9] while ignoring all of the extensive legislative history showing that the IMD provision, when first enacted and later, was consistently recognized by all, including the most involved members of Congress, as encompassing only mental hospitals. Here again, the analysis of the Second Circuit court is directly at odds with the view of the legislative history taken by the District Court and by the courts in the Minnesota and Illinois cases.[10] *See* App. C, pp. 9c-20c; App. E, pp. 18e-23e; App. F, p. 2f.

While fuller argument would confirm the error of the Second Circuit court's analysis, it suffices now to show that both that court and the Eighth Circuit court addressed the same question of statutory interpretation and reached opposite results upon consideration of the statutory provisions and the legislative history. Only a decision by this Court can resolve the conflict in interpretation of this important provision of the Medicaid law.

B. The Decision Below Conflicts With This Court's Prior Readings Of The IMD Provision.

In its submissions to the courts below, Connecticut showed that the statutory term "institution for mental diseases" was intended to encompass only mental hospitals, not alternatives like ICFs that offered a lower level of care. That understanding

[9] The excerpts relied on by the court were never cited or relied upon either by the Grant Appeals Board or by DHHS in any of the briefs filed in the courts below.

[10] The court below misconstrued the hearing excerpts on which it did rely. The principal testimony cited by the court came from spokesmen for the National Association of State Mental Health Program Directors. The January 1972 statement on behalf of that organization recognized not only that the IMD exclusion was confined to mental hospitals, but that the ICF provisions added to the Medicaid statute in December 1971 provided an alternative in the Medicaid program for care of the mentally ill. *See* Social Security Amendments of 1971: Hearings on H.R. 1 Before the Senate Committee on Finance, Pt. 2, 92d Cong., 1st & 2d Sess. 940 (1972).

of the intent of Congress is reflected in this Court's decision in *Schweiker* v. *Wilson,* 450 U.S. 221 (1981). There the Court was considering a provision of the Supplemental Security Income program (Title XVI of the Social Security Act) that was affected by the IMD exclusion in the Medicaid program.[11] Both the majority and dissenting opinions characterized the IMD exclusion as applying to mental hospitals. The opinion for the Court, relying on the legislative history of the 1965 Act, stated that the IMD provision was adopted because "long-term care in such *hospitals* had traditionally been accepted as a responsibility of the States." *Id.* at 237 n.19, quoting from S. Rep. No. 404, Pt. I, 89th Cong., 1st Sess. 144 (1965) (emphasis supplied). Mr. Justice Powell's dissenting opinion on behalf of four Justices went further and explained the rationale of the IMD exclusion as follows:

> "The residual exclusion of large state institutions for the mentally ill from federal financial assistance rests on two related principles: States traditionally have assumed the burdens of administering this form of care, and the Federal Government has long distrusted the economic and therapeutic efficiency of large mental institutions." *Id.* at 242 (citing the 1965 Senate Report).[12]

[11] The question in that case was whether the payment of subsistence allowances to certain Supplemental Security Income recipients residing in institutions, but not to those aged 21 through 64 in IMDs, created a constitutionally impermissible classification.

[12] Other courts that have considered the IMD exclusion also have characterized it only in terms of mental hospitals, based on a reading of the legislative history. *See, e.g.,* Doe v. Colautti, 592 F.2d 704, 709 (3d Cir. 1979) (referring to exclusion as relating to "inpatient care at a psychiatric hospital"); Kantrowitz v. Weinberger, 388 F. Supp. 1127, 1130 (D.D.C. 1974), *aff'd,* 530 F.2d 1034 (D.C. Cir.), *cert. denied,* 429 U.S. 819 (1976) (describing exclusion as relating to payments for inpatient care in mental hospitals); Legion v. Richardson, 354 F. Supp. 456, 459 (S.D.N.Y.), *aff'd sub nom.* Legion v. Weinberger, 414 U.S. 1058 (1973) (noting Congress' belief that care of the mentally ill "in state hospitals" was the responsibility of the states). The latter two decisions were cited with approval by the Court in *Schweiker* v. *Wilson, supra,* at 237 n.19.

Connecticut relied on the *Schweiker* case in its briefs below to support its argument that the term IMD was meant to cover only mental hospitals and did not embrace ICFs. But the court below did not refer to the *Schweiker* case, and the court's analysis of the IMD provision is inconsistent with the understanding of that provision on which the opinions in the *Schweiker* case were premised.

C. The Scope Of Medicaid Coverage For Needy Mentally Ill People Under Age 65 Is An Important And Recurring Issue.

The question whether the limitation on Medicaid coverage for services in IMDs extends to ICFs and other less intensive forms of care for persons whose mental condition requires treatment is an important one that will affect states throughout the country, all of which participate in the Medicaid program and provide ICF services for the mentally ill. The Grant Appeals Board decision was the first of its kind, but already other states have been confronted with similar disallowances.[13] Tens of millions of dollars in federal funds have been granted to the states to reimburse the costs of ICF services to persons with mental conditions. The decision below puts many of those grants in jeopardy of after-the-fact disallowance, and thus poses a major new fiscal problem for hard-pressed state governments.[14]

Moreover, unless the conflict between the circuit courts is resolved, certain states will be denied federal Medicaid funding for identical ICF services that are supported by federal Medicaid funding in other states. The need for consistent application of the Medicaid statute among the states of the union is manifest. Here, the problem is particularly acute because of the

[13] For example, a Massachusetts disallowance has been upheld by the Grant Appeals Board, and the state has initiated an action seeking judicial review. Massachusetts v. Heckler, No. 83-2239-MC (D. Mass., filed August 1, 1983). Another disallowance involving Colorado is pending before the Grant Appeals Board.

[14] There is no time limitation in the statute or regulations on federal audit and disallowance of federal funding previously provided to states in the Medicaid program.

recurring nature of the issue on which the courts have reached conflicting decisions. States throughout the country continue to provide services to mentally ill people in ICFs who meet the eligibility requirements for Medicaid. The states are subject to recoupment of the federal share of the cost of these services if the ICFs are later found to be IMDs. Thus, the question of the meaning of the IMD exclusion continues to be a matter of great moment, and needs to be definitively resolved.

Beyond this, the question raised in this case goes directly to the type of health care available to needy people. At stake is whether, as envisioned by Congress, less fortunate people of our nation who suffer from mental conditions requiring treatment can have access to less intensified (and less expensive) settings—such as ICFs—under the Medicaid law. Since Congress clearly intended use of the Medicaid program to encourage the development of such alternatives to IMDs for dealing with the problems of the mentally ill,[15] the actions of DHHS prohibiting Medicaid coverage for ICFs primarily devoted to residents with mental conditions are in direct conflict with the Congressional intent.

In sum, the question of the scope of the IMD exclusion under Medicaid l: w calls for definitive resolution. This issue represents "an important question of federal law which has not been, but should be, settled by this court . . . ." Sup. Ct. R. 17.1(c).

---

[15] The court below acknowledged this Congressional policy, but erroneously read it as applying only to care for the elderly (App. A, pp. 11a-12a), a limitation not included in the statute. *See* note 7, p. 7, *supra*.

CONCLUSION

For the reasons stated, the writ of certiorari should be issued.

Respectfully submitted,

DONALD M. LONGLEY
Assistant Attorney General
90 Brainard Road
Hartford, Connecticut 06114

CHARLES A. MILLER*
MICHAEL A. ROTH
Covington & Burling
1201 Pennsylvania Avenue, N.W.
P.O. Box 7566
Washington, D.C. 20044
(202) 662-6000

Attorneys for Petitioner State of Connecticut, Department of Income Maintenance

*Counsel of Record

June 1984

APPENDIX A

United States Court of Appeals

FOR THE SECOND CIRCUIT

No. 245—August Term, 1983
(Argued September 26, 1983 Decided March 30, 1984)
Docket No. 83-6105

STATE OF CONNECTICUT, DEPARTMENT OF INCOME MAINTENANCE,

Plaintiff-Appellee,

v.

MARGARET M. HECKLER, SECRETARY, and the UNITED STATES DEPARTMENT OF HEALTH and HUMAN SERVICES,

Defendants-Appellants.

Before:

MANSFIELD, KEARSE and WINTER,

Circuit Judges.

Appeal from an order of the United States District Court for the District of Connecticut (M. Joseph Blumenfeld, *Judge*), reversing a decision by the United States Department of Health and Human Services which disallowed federal Medicaid payments to the State of Connecticut for services provided to patients at Middletown Haven Rest Home.

Reversed.

CHARLES A. MILLER, Washington, D.C. (Joan E. Donoghue, Covington & Burling, Washington, D.C., Joseph I. Lieberman, Attorney General, State of Connecticut, Edmund Walsh, Assistant Attorney General, State of Connecticut, on the brief), *for Plaintiff-Appellee.*

SUSANNE M. LEE, Washington, D.C. (Juan A. del Real, Ann T. Hunsaker, Department of Health and Human Services, Washington, D.C., on the brief), *for Defendants-Appellants.*

WINTER, *Circuit Judge:*

The United States Department of Health and Human Services ("HHS") appeals from Judge Blumenfeld's decision that HHS improperly disallowed Medicaid payments to the State of Connecticut Department of Income Maintenance ("Connecticut") for services provided patients at Middletown Haven Rest Home ("Middletown Haven"). Judge Blumenfeld held that the statutory provisions relied on by HHS only preclude Medicaid payments for services rendered at "mental hospitals," which are "facilities which . . . provide total care to mental patients." *Connecticut* v. *Schweiker,* 557 F.Supp. 1077, 1090-91 (D. Conn. 1983). Because Middletown Haven, a duly certified intermediate-care facility ("ICF"), does not provide total care to such patients, Judge Blumenfeld concluded that HHS wrongfully had disallowed Medicaid payments for services provided there.

We reverse.

BACKGROUND

This case arises under the Medicaid legislation, Title XIX of the Social Security Act, enacted as part of the Social Security Amendments of 1965, Pub. L. No. 89-97, § 121, 79 Stat. 286, 343-52 (codified as amended at 42 U.S.C. § 1396 *et seq.*). Congress established Medicaid "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae,* 448 U.S. 297, 301 (1980). Medicaid provides federal financial assistance for certain categories of medical treatment, including "inpatient hospital services (other than services in an institution for . . . mental diseases)," 42 U.S.C. § 1396d(a)(1), "skilled nursing facility services (other than services in an

institution for . . . mental diseases)," *id.* at § 1396d(a)(4A), and "intermediate care facility services (other than such services in an institution for . . . mental diseases)," *id* at §1396d(a)(15). This assistance is also subject to two blanket provisions, one forbidding federal financial assistance "with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for . . . mental diseases," *id.* at §1396d(a)(18)(B), and the other authorizing federal financial assistance for "inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for . . . mental diseases," *id.* § 1396d(a)(14).

The statute defines ICF's as

> licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

Id. § 1396d(c). The term "institution for mental diseases" ("IMD") is not defined in the statute but has been interpreted by HHS to mean any institution "primarily engaged in providing diagnosis, treatment or care of persons with mental diseases." 42 C.F.R. § 435.1009. The parties agree that the dispositive issue in the instant case is whether an ICF such as Middletown Haven can be deemed an IMD, given the foregoing statutory and regulatory framework.

Because the statutory provisions at issue here were enacted in a piecemeal fashion, the sequence as well as the substance of the various parts of the statutory scheme is significant. The original Medicaid statute authorized federal financial assistance for inpatient hospital services and skilled nursing facility services except when rendered in an IMD, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 351 (1965) (codified as amended at 42 U.S.C. § 1396d(a)(1), (4)(A)). The original statute also

contained the blanket provisions authorizing financial assistance for those services to patients 65 or older in IMD's, *id.*, 79 Stat. at 352 (codified as amended at 42 U.S.C. § 1396d(a)(14)), but precluding it for those services to patients under age 65 in an IMD, *id.* (codified as amended at 42 U.S.C. § 1396d(a)(18)(B)). The original Medicaid statute made no provision for financial assistance for ICF services.

In 1967, Congress authorized federal assistance for ICF services under special programs for the aged, the blind and the disabled. Social Security Amendments of 1967, Pub. L. No. 90-248, § 250, 81 Stat. 821, 920 (repealed 1971). ICF coverage to those eligible under the Medicaid program was authorized in 1971, Pub. L. No. 92-223, § 4, 85 Stat. 802, 809 (1971), when Congress repealed the 1967 legislation and brought ICF coverage under the Medicaid program. However, in doing so, Congress expressly excluded ICF services rendered in an IMD.[1] *Id.* § 4(a)(1)(C), 85 Stat. 802, 809 (codified as amended at 42 U.S.C. § 1396d(a)(15)). The ICF definition adopted in the 1971 Medicaid legislation, which is quoted *supra*, resembled that used in the 1967 legislation, except that the 1971 definition explicitly stated that "the term 'intermediate care facility' shall not include . . . any public institution or distinct part thereof for mental diseases or mental defects." *Id.* § 4(a)(2) (codified at 42 U.S.C. § 1396d(c)). An exception to this general exclusion was made for public institutions treating the mentally retarded. *Id.* (codified at 42 U.S.C. § 1396d(d)). The 1971 definition is the one at issue in the instant case.

From the time that Middletown Haven began operation as an ICF in 1977, Connecticut received federal Medicaid funds to help defray the costs of services provided patients at the facility. The legality of this arrangement came under scrutiny in December 1979, when an audit team from HHS undertook a study of

[1] By oversight, the 1971 legislation did not explicitly declare that the IMD exclusion did not prevent the use of Medicaid funds to reimburse states for ICF services provided the elderly in IMDs. A technical amendment was passed in 1972 to clarify this point. Social Security Amendments of 1972, Pub. L. No. 92-603, § 297(a), 86 Stat. 1329, 1459-60 (codified at 42 U.S.C. § 1396d(a)(14)); *see* S. Rep. No. 1230, 92d Cong., 2d Sess. 320-21 (1972).

patient records at Middletown Haven. The study was conducted as part of an investigation by HHS to determine whether certain states were discharging patients from mental hospitals and arranging their placement in ICF's in order to circumvent the Medicaid exclusion for patients under age 65 in IMD's. Applying internal criteria developed by HHS and intended to supplement the IMD definition set forth in the regulations,[2] the audit team concluded that Middletown Haven was an IMD. In drawing this conclusion, it found, *inter alia*, that 77% of the patients treated from January, 1977 through December, 1979 were suffering from a major mental disease that was responsible in substantial part for their need of ongoing care, that more than 50% of the patients had been admitted directly from state mental hospitals, and that Middletown Haven hired professional staff, including three psychiatrists, who specialized in the care of the mentally ill. Following the audit team's report, HHS disallowed all Medicaid payments made for services provided patients at Middletown Haven between January, 1977 and September, 1979—an amount totalling $1,634,655.[3]

[2] The HHS criteria instruct audit teams to focus on the following characteristics of the institution at issue:

1. Licensed as a mental institution.
2. Advertised as a mental institution.
3. More than 50% of the patients have a disability in mental functioning.
4. Used by mental hospitals for alternative care.
5. Patients who may have entered mental hospitals are accepted directly from the community.
6. Proximity to State mental institutions (within a 25 mile radius).
7. Age distribution uncharacteristic of nursing home patients.
8. Basis of Medicaid eligibility for patients under 65 is due to mental disability.
9. Hires staff specialized in the care of the mentally ill.
10. Independent professional reviews conducted by state teams report a preponderance of mental illness among patients in the facility.

[3] Of the amount disallowed by HHS, $1,137,138 was for services provided patients between the ages of 21 and 65, and $497,517 for services provided patients in other age groups. Under the Medicaid statute, states have the option to choose whether they wish to receive federal financial assistance for services provided patients over age 65 in IMD's. *See* 42 U.S.C.

(footnote continues)

Connecticut then sought agency review of the disallowance. Its appeal, consolidated with appeals from similar disallowances by the states of Minnesota, Illinois and California, was heard before the Departmental Grant Appeals Board of HHS. On November 30, 1981, the appeals were denied in all respects, a decision which constituted the final administrative agency action in this matter. Each state then sought judicial review. Connecticut petitioned for direct appellate review—an action we earlier dismissed for want of jurisdiction, *Connecticut* v. *Schweiker,* No. 82-4023 (2d Cir. Apr. 20, 1982)—and also filed a complaint in district court seeking reversal of the disallowance.[4] Ruling on cross motions for summary judgment, Judge Blumenfeld reversed the agency decision, concluding that the IMD definition used by HHS in ordering the disallowance was incompatible with the congressional intent underlying the IMD exclusion. This appeal followed.

(footnote continued)

§ 1396a(10), (20), (21). During the period relevant here, Connecticut did not exercise the option. The HHS audit team conceded that had Connecticut done so, federal financial assistance would have been allowed for the services provided Middletown Haven patients age 65 and over.

The statute requires that the Secretary of HHS recover disallowed Medicaid payments by offsetting such payments against future quarterly advances. 42 U.S.C. § 1396b(d)(2). It cannot be determined from the record whether this procedure has been followed in the instant case. Judge Blumenfeld assumed that once his decision was filed, HHS would "promptly restore any setoff already taken." *Connecticut* v. *Schweiker,* 557 F.Supp. at 1091. Again, the record is silent on whether HHS has done so. However, the parties have not requested judicial resolution of the matter.

[4] Illinois sought direct appellate review of a disallowance and its appeal was also dismissed for want of direct appellate jurisdiction. *Illinois* v. *Schweiker,* 707 F.2d 273 (7th Cir. 1983). The Seventh Circuit held that if judicial review of the disallowance were available, it would lie initially in district court. 707 F.2d at 279.

Minnesota has secured a declaratory judgment holding that HHS acted improperly in disallowing Medicaid payments made for services provided in three ICF's in that state. *Minnesota* v. *Heckler,* 718 F.2d 852 (8th Cir. 1983). The Eighth Circuit concluded that HHS had acted improperly in focusing on the diagnosis of patients in its decision that the ICFs at issue were also IMDs. 718 F.2d at 866. We disagree with the Eighth Circuit for reasons set forth *infra.*

We are informed that California has sought district court review of its IMD-based disallowance, but no decision has been reported.

DISCUSSION

Having previously decided that direct appellate jurisdiction is not available in this case, our threshold task is to determine whether jurisdiction exists in any federal court to review the decision of the HHS Departmental Grant Appeals Board. Because the decision is in every sense a "final agency action for which there is no other adequate remedy in a court," Administrative Procedure Act, 5 U.S.C. § 704 (1976), judicial review is available unless clearly forbidden by Congress. *Abbott Laboratories* v. *Gardner,* 387 U.S. 136, 140-41 (1967). We agree with the Ninth Circuit that there is no indication that Congress meant to bar review of disallowance decisions, *County of Alameda* v. *Weinberger,* 520 F.2d 344, 347-49 (9th Cir. 1975), and thus proceed to the merits.

The gravamen of Connecticut's argument is that the IMD exclusion was intended to foreclose federal financial assistance only for services provided in traditional state mental hospitals. Contending that IMD's and ICF's are mutually exclusive categories of institutions, Connecticut maintains that Congress intended that federal assistance be available for the services in question so long as they are provided in ICF's. The policy supposedly underlying this distinction is designed to encourage the placement of mental patients in ICF's, an alternative and favored type of facility. In short, according to Connecticut, what mattered to Congress was not that IMD patients suffered a particular type of illness, but that they were treated in a type of facility that Congress was unwilling to fund.

We disagree with that view of the statute. Both the statutory language and the legislative history demonstrate that, with certain specific exceptions not at issue, Congress has explicitly declined to permit the use of Medicaid funds for custodial care and treatment of the mentally ill under age 65, regardless of the type of facility in which that care and treatment are provided. Because the criteria used by HHS in designating Middletown Haven an IMD seem reasonably tailored to implement this Congressional intent, the disallowance was proper. Accordingly, we reverse.

Our analysis begins with the language of the statute. In Connecticut's view, the most significant statutory provision is the definition of ICF, which explicitly mentions care offered to patients who require it "because of their mental . . . condition." 42 U.S.C. § 1396d(c)(1). Connecticut invokes the inclusion of this language as proof that Congress intended that Medicaid funds be available for services to mental patients provided in ICF's such as Middletown Haven.

There is logic in that argument, but it is not conclusive since the statutory language may refer to ICF treatment of some but not all categories of mental patients. If a state has chosen to extend Medicaid coverage to persons age 65 and over in IMD's, *see supra*, note 3, such persons are covered for mental conditions regardless of whether treatment is provided in a hospital, skilled nursing facility or ICF, *id.* § 1396d(a)(14). The language may thus refer to aged patients with mental illness. Second, the statute clearly provides for the establishment of public ICF's for the treatment of the mentally retarded, *id.* § 1396d(d), and the language may also apply to patients in this category. Third, all parties agree that an ICF is not rendered an IMD simply by providing treatment to some patients who require it because of mental condition; rather, the test is whether the "overall character" of a facility makes it an IMD, 42 C.F.R. § 435.1009. The statutory definition of ICF can logically, therefore, include institutions with mental patients without extending federal assistance to all such patients, since it is clear that some mental patients in ICF's are not excluded from Medicaid assistance.

Like Connecticut, HHS relies upon a statutory provision which it regards as conclusive. That provision authorizes the payment of Medicaid funds for "intermediate care facility services (other than such services in an institution for . . . mental diseases)." 42 U.S.C. §1396d(a)(15). In HHS's view, Congress forbade the use of Medicaid funds to cover ICF services provided in an IMD, a term which Congress did not define but which HHS has reasonably construed to include any institution primarily engaged in the treatment of

mental diseases. 42 C.F.R. § 435.1009. Connecticut rejoins that the ban on reimbursement for ICF services provided in an IMD simply means that ICF services are not covered only if they are provided in a type of institution excluded under the statute, *i.e.* the IMD or traditional mental hospital. In Connecticut's view, Congress phrased the exclusion in order to prevent states from obtaining Medicaid reimbursement for ICF-level services provided in traditional mental hospitals; conversely, it argues, so long as ICF services are offered in independent ICF's, Congress intended that Medicaid funds be available. Thus, Connecticut argues, because ICF's and IMD's are mutually exclusive types of facilities and Congress did not contemplate circumstances under which an ICF would be confused with an IMD, the exclusion for ICF services rendered in an IMD is irrelevant.

We believe HHS's view is the more plausible. First, Connecticut's reading asks us to believe that, while Congress intended to encourage the use of ICF's, it expressly forbade financial assistance to effect even the partial transformation of state mental hospitals into ICF's. We perceive no reason whatsoever to conclude that Congress intended to deter the development of ICF's within the traditional hospital, particularly since transforming part of an existing facility might be considerably less expensive than development of a new institution. The distinction proferred by Connecticut treats an ICF operated within an IMD differently from an independent ICF even though the nature of the patients treated and services offered are identical. No congressional purpose calling for such an artificial distinction has been offered, and we have found none in our independent research.

Second, the statutory language strongly suggests that Congress believed that even an independent ICF which provided care and services to the mentally ill might be an IMD. Congress authorized the payment of Medicaid funds for "inpatient hospital services (other than services in an institution for . . . mental diseases)," 42 U.S.C. § 1396d(a)(1), for "skilled nursing facility services (other than services in an institution for . . . mental diseases)," *id.* § 1396d(a)(4A), and

"intermediate care facility services (other than such services in an institution for . . . mental diseases)," *id.* §1396d(a)(15). Unless one accepts the artificial distinction between an ICF operated independently of an IMD and an ICF connected with an IMD, these identical exclusions strongly imply that Congress contemplated that any of the three types of facilities—the hospital, the skilled nursing facility and the ICF—might qualify under certain circumstances as an IMD. Moreover, the definition of an ICF states that "the term 'intermediate care facility' shall not include . . . any public institution . . . for mental diseases or mental defects," 42 U.S.C. § 1396d(c), except for public ICFs "for the mentally retarded or persons with related conditions," *id.* § 1396d(d). Since the exclusion for IMD's does not distinguish between public and private facilities, the combination of Sections 1396d(a)(15), 1396d(c) and 1396d(d) makes sense only as a statement that ICF's which are IMD's are excluded from the definition except those public ICF/IMD's which care for the mentally retarded. In short, the provisions are meaningless unless some ICF's are IMD's and thus subject to the statutory exclusion.

A review of the legislative history fully supports the view that these provisions are not meaningless but the result of a conscious congressional design to support care for the elderly suffering from mental illness, including the encouragement of alternatives to the traditional mental hospital, while excluding coverage to those under age 65. The forerunner of the IMD exclusion was enacted in 1950, when Congress authorized the payment of federal old-age assistance to the elderly residing in public medical institutions.[5] Social Security Amendments of 1950, Pub. L. No. 81-734, § 303(a), 64 Stat. 477, 549. Congress refused, however, to authorize such payments for the elderly residing in "public or private institutions for mental illness or tuberculosis," on the grounds that care of such patients traditionally had been the responsibility of the states, H.R. Rep. No. 1300, 81st Cong., 1st Sess. 42 (1949).

[5] Such assistance previously had been available only to the elderly residing in private institutions. H. R. Rep. No. 1300, 81st Cong., 1st Sess., 42 (1949).

The original IMD exclusion, as amended,[6] continued in force until 1965, when Congress enacted the Medicaid statute and established a comprehensive program of federal financial assistance for medical care to the indigent. That statute made federal financial assistance for the treatment of the mentally ill dependent on age. With respect to care provided the indigent mentally ill under age 65, no federal funds were available for treatment in IMD's, but such funds were available for treatment provided in general hospitals. With respect to the indigent over 65, the Medicaid statute omitted an IMD exclusion analogous to the one which was enacted some fifteen years before. An expressly stated purpose behind lifting the IMD exclusion for those over 65 was to encourage states to permit the elderly to receive mental health care in a variety of settings that would serve as alternatives to confinement in the traditional mental hospitals; among these alternatives were nursing homes, general hospitals and foster families, S. Rep. No. 404, Pt. 1, 89th Cong., 1st Sess. 145, *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 2084-87. Indeed, state access to Medicaid funds for the treatment of aged persons in IMD's was contingent on the development of state plans for the provision of alternative forms of mental health care to the elderly. Social Security Amendments of 1965, Pub. L. No. 89-97 § 121(a), 79 Stat. 286, 347 (codified at 42 U.S.C. § 1396a(20), (21)); *see* S. Rep. No. 404, *supra,* at 145.

Much of Connecticut's argument that Congress intended to encourage the provision of alternative care to that provided in traditional mental hospitals is actually drawn from legislative history explaining Congress' decision to lift the IMD exclusion as to *the elderly*. *See, e.g.,* Brief of Appellee at 18-19. Similarly, congressional discussion of alternative types of care took place in the context of treatment provided to *the elderly*. *See, e.g.,* S. Rep. No. 404, *supra,* at 145. Lengthy and repeated quotation from the legislative history concerning alternative types of care

[6] In 1960 Congress modified the IMD exclusion to permit payment for the first six weeks of care in a "medical institution" for the aged who required such care "as a result of a diagnosis of . . . psychosis." Social Security Amendments of 1960, Pub. L. No. 86-778, § 601(2)(f)(2), 74 Stat. 924, 991.

for the elderly merely underlines the absence of any such history supporting Connecticut's position as to persons under age 65, a central issue in the instant litigation. The fundamental and ultimately fatal weakness of Connecticut's argument is the undeniable fact that Congress has never lifted the longstanding IMD exclusion for persons under age 65 or even indirectly implied such a purpose in the legislative history.

To the contrary, on at least three of the occasions on which Congress amended the Medicaid program in the seven years after 1965, explicit proposals to lift the IMD exclusion as to those under age 65 were made in hearings on the Medicaid legislation to no avail. On each occasion a proposal was made to make Medicaid funding available for the treatment for the mentally ill under age 65, not simply in traditional mental hospitals, but also in alternative treatment settings. In 1967 the Senate Finance Committee was told during hearings on Medicaid legislation that the effect of the broad availability of Medicaid funds for the treatment of the elderly mentally ill was to permit "the psychiatrist to utilize the full range of modern psychiatric facilities for the treatment of the older patient," but that the effect of the IMD exclusion for the population under age 65 was to preclude Medicaid funds for the treatment of the mentally ill under age 65 in any "mental institution, whether it be a public or private mental hospital, or even a community health center." Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance, Pt. 3, 90th Cong., 1st Sess. 1741 (1967) (Statement of Dr. Robert W. Gibson, Am. Psychiatric Ass'n). Nevertheless, Congress refused to act.

This appeal was renewed in Senate hearings in 1970, and once again Congress refused to change the law. *See* Social Security Amendments of 1970: Hearings on H. R. 17550 Before the Senate Comm. on Finance, Pt. 2, 91st Cong., 2d Sess. 500-50 (1970). Moreover, in the same hearings, supporters of expanded federal assistance for the mentally ill and mentally retarded protested the House's modification of the statutory definition of an ICF.[7] *See, e.g., id.* at 504-09 (Testimony of

[7] Federal funding had been available since 1967 for ICF care provided to the aged, the blind, and the totally and permanently disabled. *See supra.*

Kenneth D. Gaver, M.D., Administrator, Or. Div. Mental Health). The House language modified the ICF definition to exclude "any public institution (or distinct part thereof) for mental diseases or mental defects." H. R. 17550, 91st Cong., 2d Sess. § 225(b)(2) (1970). The Senate was warned by those proposing expanded financial assistance to the mentally ill that for those patients eligible for federally supported ICF services, this language would forbid "a supportive program of care of a semimedical nature" for the mentally ill and a "supportive program of care of a social service-rehabilitative type" for the mentally retarded. *Id.* at 501-02 (Testimony of Harry Schnibbe, Executive Director, Nat'l Ass'n of State Mental Health Program Directors). When ICF services were made part of the Medicaid program in December, 1971, the language passed by the House in reference to the earlier ICF program was retained but modified to permit support for public ICF's treating the mentally retarded. Pub. L. No. 92-223, § 4, 85 Stat. 802, 809 (1971) (codified at 42 U.S.C. § 1396d(c), (d)). For present purposes the most conspicuous feature of the statutory definition of an ICF is the absence of any provision authorizing public ICF's for the mentally ill, although this too had been sought in the hearings before the Senate Finance Committee. This episode thus suggests two conclusions: (1) Congress did not consider ICF's and IMD's as mutually exclusive categories; and (2) Congress declined to enact an ICF definition which included ICF's treating the mentally ill, although it was explicitly asked to do so.

The third, and for purposes of our inquiry most important, effort to eliminate the IMD exclusion occurred in January, 1972. *See* Social Security Amendments of 1971: Hearings on H.R. 1 Before the Senate Comm. on Finance, Pt. 2, 92nd Cong., 1st & 2nd Sess. 924 (1972) (Statements of Dr. Jonathan Leopold, Comm'r, Vt. Dept. of Mental Health & Dr. Kenneth Gaver, Comm'r, Ohio Dept. of Mental Hygiene & Corrections). In these hearings, which occurred some three weeks after passage of the legislation which brought ICF coverage under the Medicaid program and which Connecticut claims is dispositive of this litigation, the Senate Finance Committee heard for the

third time an appeal by state mental health officials to lift the IMD exclusion for those under age 65. As part of this appeal, the salutary consequences of lifting the IMD exclusion for the aged were described; one such consequence was that elderly patients were discharged from traditional state mental hospitals "into nursing homes, into *intermediate care facilities*" and into other alternative settings. *Id.* at 928 (emphasis added). The state officials argued that "[t]he principle of equity requires that the benefits presently provided to mentally ill persons over 65 be made available to persons of all ages." *Id.* at 929. These officials thus believed that under the then existing statutory framework—a framework virtually identical to the one at issue in the instant litigation—states could not discharge patients under age 65 from mental hospitals, arrange their placement in ICF's and then look to the Medicaid program for financial support.

Responding to this presentation, Senator Long, Chairman of the Senate Finance Committee and a key political figure in the legislative process, warned state officials that their proposal would be perceived as too costly and asked whether as an alternative they would "support an amendment to cover the mentally ill [under age 65] under Medicaid who receive active care and treatment in an accredited medical institution." *Id.* at 929. Ultimately, Congress provided even less than the compromise offered by Senator Long, for it approved only limited relief from the IMD exclusion by permitting the use of Medicaid funds for inpatient psychiatric hospital services to patients under age 21. Pub. L. No. 92-603, § 299B, 86 Stat. 1329, 1460-61 (1972) (codified at 42 U.S.C. § 1396d(a)(16),(h)). A pilot program approved by the Senate to test "the potential benefits of extending medicaid mental hospital coverage to mentally ill persons between the ages of 21 and 65" was rejected by the House and dropped in conference. *See* S. Rep. No. 1230, 92d Cong., 2d Sess. 57; H. R. Rep. No. 1605, 92d Cong., 2d Sess. 65 (Conf. Rep.), *reprinted in* 1972 U.S. Code Cong. & Ad. News 5370, 5398. The IMD exclusion thus remained virtually in full force, as Congress declined to extend full Medicaid coverage for the treatment of the mentally ill between the ages of 21 and 65.

The import of this legislative history is clear. The IMD exclusion was perceived to block the use of Medicaid funds to help pay for the care of the mentally ill under age 65 in a broad range of institutions subsumed under the label "institution for mental diseases," including ICF's. Congress was asked repeatedly to lift this exclusion in whole or in part and refused.

Against this record of legislative history, Connecticut offers only a statement prepared by the Senate Finance Committee and offered by Senator Long in support of the December, 1971 legislation transferring ICF coverage to the Medicaid program. The statement declared that "intermediate care coverage is for persons with health-related conditions who require care beyond residential care or boarding home care, and who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital." 117 Cong. Rec. 44,721 (1971). Connecticut argues from this that Congress intended that Medicaid funding be available for services provided to all patients who otherwise would be in a mental hospital subject to the IMD exclusion. One need not interpret this language so broadly, however. The legislation effecting the transfer made the IMD exclusion applicable to ICF services provided patients under age 65 and was considered by Senator Long to bar Medicaid funding for services provided patients under 65 discharged from mental hospitals and placed en masse in ICF's, as he implicitly acknowledged in the Finance Committee hearings which took place some six weeks after the quoted statement. Given that the Senate Finance Committee statement also speaks of the transfer of ICF coverage from Title XI, federal old age assistance, to the Medicaid program in order to subject ICF's to federal standards and to reduce the placement of patients in skilled nursing facilities who only required less expensive ICF care, *id.*, it is wholly plausible to conclude that the quoted language refers to ICF services available to the elderly and not subject to the IMD exclusion.

For the foregoing reasons we are convinced that the IMD definition adopted by HHS and supplemented by its internal criteria reasonably implements Congress' intent. Connecticut's

principal complaint is that the IMD definition and criteria adopted by HHS improperly focus on the nature of patients' illnesses rather than the type of care furnished at the facility in question. However, the IMD exclusion virtually compels HHS to focus on the nature of the illnesses treated rather than the care furnished. Except for the use of Medicaid funds to treat the mentally ill under age 65 in general hospitals and patients under age 21 in psychiatric hospitals, Congress has not modified the IMD exclusion to differentiate among types of custodial facilities treating the mentally ill. It is not for us to disturb this decision.

Reversed and remanded for entry of judgment consistent with this opinion.

APPENDIX B

United States Court of Appeals

FOR THE SECOND CIRCUIT

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the thirtieth day of March, one thousand nine hundred and eighty-four.

PRESENT:

HON. WALTER R. MANSFIELD

HON. AMALYA L. KEARSE

HON. RALPH K. WINTER

Circuit Judges,

83-6105

STATE OF CONNECTICUT,
DEPARTMENT OF INCOME MAINTENANCE,
Plaintiff-Appellee,

v.

MARGARET M. HECKLER, SECRETARY, and
The UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES,
Defendants-Appellants.

(filed March 30, 1984)
Appeal from the United States District Court for the District of Connecticut.

This cause came on to be heard on the transcript of record from the United States District Court for the District of Connecticut, and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now hereby ordered, adjudged, and decreed that the order of said District Court be and it hereby is reversed and the action be and it hereby is remanded to the said district court for further proceedings in accordance with the opinion of this court with costs to be taxed against the appellee.

ELAINE B. GOLDSMITH,
Clerk

/s/ Edward J. Guardaro,

By: Edward J. Guardaro,
Deputy Clerk

APPENDIX C

United States District Court

DISTRICT OF CONNECTICUT

CIVIL NO. H-82-146

STATE OF CONNECTICUT,
DEPARTMENT OF INCOME MAINTENANCE

v.

RICHARD S. SCHWEIKER, SECRETARY, AND THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

RULING ON CROSS-MOTIONS FOR SUMMARY JUDGMENT

(filed February 17, 1984)

I. PROCEDURAL HISTORY

In this suit, the State of Connecticut challenges the final administrative decision by the Department of Health and Human Services (HHS) that Connecticut's expenditures to the privately owned Middletown Haven Rest Home are not eligible for federal reimbursement under the Medicaid program, Title XIX of the Social Security Act (codified as amended at 42 U.S.C. §§ 1396-1396m (1976 & Supp. IV 1980) and 42 U.S.C.A. §§ 1396-1396n (West 1974 & Supp. 1981)).

HHS[1] advanced funds quarterly to Connecticut for expenses for patient care at Middletown Haven Rest Home. The advances covered the period from the home's opening in January 1977 through September 1979. This advance of funds was pursuant to 42 U.S.C. § 1396b(d)(2) (1976), as Con-

[1] Until 1980, the role of HHS was played by HHS's predecessor, the Department of Health, Education and Welfare (HEW). For convenience, I refer only to HHS.

necticut had identified Middletown Haven as an "intermediate care facility" (ICF) eligible for reimbursement under 42 U.S.C. § 1396d(a)(15) (1976). In 1980, following an audit of Middletown Haven covering the above time period, the Health Care Financing Administration (HCFA) of HHS decided that the expenses at Middletown Haven had in fact not qualified for reimbursement because Middletown Haven, though an ICF, was also an "institution for mental diseases" (IMD), 42 U.S.C. §§ 1396d(a)(15), 1396d(a)(B) (1976). HCFA thus disallowed the federal reimbursement. Connecticut appealed this decision to the HHS Departmental Grant Appeals Board. The board sustained HCFA in Decision No. 231, dated November 30, 1981 (hereinafter, Decision 231). Having made this decision, HHS is required to offset the disallowed payments from future quarterly advances. 42 U.S.C. § 1396b(d)(2) (1976).[2] Connecticut appeals this final administrative decision.

II. JURISDICTION

A threshold matter is this court's jurisdiction.[3] The Board's decision is a "final agency action for which there is no other adequate remedy in a court." Administrative Procedure Act (APA) § 704, 5 U.S.C. § 704 (1976). Accordingly, judicial review is available unless the particular statutes concerning the Board's action "preclude judicial review." APA § 701(a), 5 U.S.C. § 701(a) (1976). Judicial review is not deemed forbidden unless the statute clearly forbids review. *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 140-41 (1967). Here, 42 U.S.C.A. § 1316(d) (West Supp. 1981) requires the Secretary to review disallowances but is silent on further review in the courts. Accordingly, review seems permitted by the doctrine of *Abbott Laboratories*. Further, the court in *County of Alameda* v. *Weinberger*, 520 F.2d 344, 347-49 (9th Cir. 1975) (Hufstedler, J., joined by Browning and Koelsch, JJ.), in

[2] A 1980 amendment allows the state to retain disallowed advances pending judicial review, but the amendment applies only to expenditures for services furnished on or after October 1, 1980. 42 U.S.C. § 1396b(d)(5) (Supp. IV 1980).

[3] HHS does not challenge this court's jurisdiction, but this court has an independent duty to examine whether it has jurisdiction.

considering the text, legislative history, and policy of section 1316(d), found no indication that Congress intended to preclude judicial review.[4]

Review of actions under section 1316(d) lies in the district court, which has subject matter jurisdiction by 28 U.S.C. § 1331 (Supp. IV 1980) (amending 28 U.S.C. § 1331 (1976)). *See Alameda*, 520 F.2d at 347, 349 (implicitly assuming that review under section 1316(d) lies in district court, and upholding such review). *See also* K. Davis, *Administrative Law Treatise* § 23.03-1 at 373 (Supp. 1982) (provision in APA section 703 for review in "court of competent jurisdiction" means, in absence of contrary statute, review in district court, which has general jurisdiction under 28 U.S.C. §§ 1331, 1337).[5]

[4] The *Alameda* court's reasoning seems applicable to any disallowance controlled by section 1316(d). Nevertheless, the court, in finding judicial review permitted, expressly limited its holding to the situation in which the agency had already used "self-help setoff procedures" to collect the amount disallowed. 520 F.2d at 349 n.11. The case at bar is little different, because, as mentioned, the Secretary is required to offset the amount disallowed against future quarterly payments, and presumably he has done so.

[5] One might argue that review of the Secretary's action is controlled not by section 1316(d) but by section 1316(a), 42 U.S.C.A. § 1316(a) (West 1974 & Supp. 1981), which provides for review in the court of appeals of the Secretary's disapproval of a state plan. On this question, I find persuasive the opinion of Chief Judge Lord in *Minnesota* v. *Schweiker*, No. 4-82-155 Civ., slip op. at 3-5 (D. Minn. Aug. 25, 1982). Judge Lord's case involved a disallowance very similar to the one in this case. Both disallowances were based on the agency's determination, after audit, to disallow funds previously advanced for care at an intermediate care facility (ICF) because the facility was also an institution for mental diseases (IMD). The cases were heard together by the HHS Departmental Grant Appeals Board, and were decided together by the Board in Decision 231. Judge Lord reviewed several cases near the boundary between sections 1316(a) and 1316(d), including the recent Third Circuit case of *New Jersey* v. *Department of Health and Human Services*, 670 F.2d 1300 (3d Cir. 1982), and concluded that the disallowance in question came under section 1316(d) rather than section 1316(a) because it did "not concern the validity of Minnesota's Medicaid plan or its overall administration" but rather was "narrowly focused upon specific reimbursement claims." Slip op. at 4-5. The same reasoning applies here.

III. THE PRESENT MOTIONS

In its complaint, Connecticut challenges HHS' action in various ways. First, the finding that Middletown Haven Rest Home was an IMD is allegedly contrary to statute, ¶¶ 19-21, contrary to regulations, ¶¶ 23-24, and based on arbitrary criteria (of which Connecticut had insufficient notice) for classifying facilities as IMDs, ¶ 26. Next, Connecticut attacks the alleged retroactive nature of the disallowance. ¶ 28. Finally, Connecticut challenges the Board's action as not supported by substantial evidence. ¶ 30.

Connecticut and HHS have both moved for summary judgment. There is some confusion over whether Connecticut's claim concerning substantial evidence is before the court on these motions. *See* Defendant's Brief at 22 n.10; Plaintiff's Reply Brief at 16 n.1; Defendant's Reply Brief at 2 n.*; Plaintiff's Supplemental Brief at 6 n.*.[6] However, the issue of statutory construction, which is definitely before the court on these motions, is sufficient to decide the motions.

---

[6] The parties have each submitted three briefs on the cross-motions for summary judgment. In order received, they are:

1. [Plaintiff's] Brief in Support of Plaintiff's Motion for Summary Judgment
2. Defendant's Memorandum in Support of Cross-Motion for Summary Judgment and in Opposition to Plaintiff's Motion for Summary Judgment
3. Plaintiff's Reply Brief
4. Defendant's Reply Memorandum in Support of Motion for Summary Judgment
5. [Defendant's] Supplemental Brief in Support of Defendant's Cross-Motion for Summary Judgment
6. Plaintiff's Response to Defendant's Supplemental Brief.

The court will refer to these briefs respectively as:

1. Plaintiff's Brief
2. Defendant's Brief
3. Plaintiff's Reply Brief
4. Defendant's Reply Brief
5. Defendant's Supplemental Brief
6. Plaintiff's Supplemental Brief.

The Supplemental Briefs discuss *Minnesota* v. *Schweiker*, No. 4-82-155 Civ. (D. Minn. Aug. 25, 1982), which was decided after this court heard oral argument on the summary judgment motions.

IV. STATUTORY CONSTRUCTION: THE VARIOUS POSITIONS

This case depends on the meaning of "institution for mental diseases" (IMD) in the Medicaid statute. The reason is that Middletown Haven qualifies for federal payments as an "intermediate care facility" (ICF) unless it is also an IMD.

The Medicaid statute provides for the federal government to share with states the costs of "intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases)." 42 U.S.C. § 1396d(a)(15) (1976). An "intermediate care facility" (ICF) is

> an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, [and also meets the Secretary's care, safety, and sanitation standards] . . . .

42 U.S.C. § 1396d(c) (Supp. IV 1980) (amending 42 U.S.C. § 1396d(c) (1976)). The statute repeats that the federal payments do not include "any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases." 42 U.S.C. § 1396d(a)(B) (1976). Thus, though ICFs in general are eligible for federal payments, ICFs which are also IMDs are ineligible.

The Grant Appeals Board, while it accepted Middletown Haven's ICF status, disallowed funds on the ground that Middletown Haven was also an IMD. Decision 231 at 35-39. In determining whether Middletown Haven was an IMD, the Board followed HHS regulations which define an IMD as a facility with the "overall character" of being "primarily for the

care and treatment of individuals with mental diseases."[7] *Id.* at 39. The Board found this definition satisfied by a combination of facts. The most important fact was that a large majority of the patients were "mental" patients. *Id.* at 36-37. Other facts included Middletown Haven's license to care for persons with psychiatric conditions, Middletown Haven's having advertised itself as a facility specializing in the care of persons with mental diseases, and the presence of three staff psychiatrists who made weekly consultations. *Id.* at 36.

The Board's decision can be upheld only if its classification of Middletown Haven was based on appropriate factors. Accordingly, HHS maintains in this court that an ICF is an IMD if it exists primarily to care for mental patients. Defendant's Brief at 9-10. Connecticut, in contrast, asserts that an "IMD" means a "state mental hospital or its private equivalent." Plaintiff's Brief at 17. Connecticut is substantially correct. An IMD means a mental hospital, which in turn means, at the least, a facility providing total care to mental patients.[8]

---

[7] HHS regulations define an IMD as

> an institution that is *primarily* engaged in providing diagnosis, treatment or care of *persons with mental diseases,* including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained *primarily for the care and treatment of individuals with mental diseases,* whether or not it is licensed as such . . . .

42 C.F.R. § 435.1009 (1980) (emphasis added). In turn, the regulations define an "institution" as

> an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

Id.

[8] I thus disagree with Chief Judge Lord in *Minnesota* v. *Schweiker,* No. 4-82-155 Civ., slip op. at 15 (D. Minn. Aug. 25, 1982), who concluded in a case very similar to the case at bar, *see supra* note 5, that "by 'institution for mental diseases' the Congress intended to refer to those institutions which provided primarily long-term care for the mentally ill by administering psychiatric treatment for its residents on the premises." I disagree because, as discussed below, the legislative history indicates on balance that long-term care and psychiatric care are not necessary for a facility to be an IMD, but that total care is. Though I disagree with Judge Lord's conclusion, I have greatly benefited from his insightful opinion.

V. STATUTORY CONSTRUCTION: ANALYSIS

A. *The Ambiguity of the Term "IMD"*

The phrase "institution for mental diseases" used in sections 1396d(a)(15) and 1396d(a)(B) is not self-explanatory. "Institution" suggests a total care situation, probably for a long time.[9] Consider, for example, the meaning of "to institutionalize" someone. "Institution" also suggests a large, impersonal establishment. Contrast the more neutral term "facility," used often elsewhere in the statute. Still, "institution" might simply be used in a neutral sense, as a synonym for "facility"; or it might, for example, denote a fairly high but not total level of care. Further, the phrase "for mental diseases" might require only that patients have mental diseases, or it might require also that some level of psychiatric treatment be given.

To discover the meaning of "IMD," first the statute's text and then its legislative history will be examined.

B. *Clues from the Statute's Text*

The statute's text is only slightly helpful in resolving the ambiguous meaning of "IMD." Three sections are relevant: sections 1396d(a), 1396d(c), and 1396a. 42 U.S.C.A. §§ 1396a, 1396d (West 1974 & Supp. 1981).

Section 1396d(a). By excluding services in an IMD from the general cost sharing of ICF services, section 1396d(a)(15), quoted *supra* p. 6, implies that ICFs may also be IMDs, but does not clarify under what circumstances this would happen. Parallel IMD exclusions in parts (1) and (4) of section 1396d(a), dealing with inpatient hospital services and skilled nursing facility services respectively, imply that these other facilities too can be IMDs, but again do not clarify just how this would happen. The same message comes from part (14), which explicitly covers "inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases."

---

[9] By "total care" I mean the very high level of care given, for example, to a hospital inpatient or a nursing home resident. The patient is totally dependent on the institution and is submerged in it.

Section 1396d(c). Section 1396d(c), quoted *supra* p. 6, defines an ICF as providing care required by patients' "mental or physical condition." This language suggests that people with mental and physical conditions ("mental patients" and "physical patients" respectively) should be treated equally. From this viewpoint, a definition of an IMD as an institution maintained primarily for mental patients would be undesirable because it would discriminate fairly directly against mental patients. A definition of an IMD at least partly in other terms, such as a requirement of total care, would discriminate much less efficiently against mental patients. Other possible defining criteria can be similarly evaluated. For example, the criterion that the facility provide psychiatric care would discriminate against mental patients more than the criterion that the facility provide total care, but less than the criterion that the facility exist primarily for mental patients.

Section 1396a. Section 1396a(21) lists "community mental health centers" as an example of "alternatives to care in public institutions for mental diseases." This section thus suggests that a "community mental health center" is not an IMD. However, it is not immediately clear what a "community mental health center" is, and whether Middletown Haven is one. Further, Congress in this section may have contemplated a *private* community mental health center, which merely because it is private is not a "*public* institution for mental diseases" (emphasis added).[10]

[10] Section 1396a(21) speaks of "community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases." Section 1396a(20) discusses "alternate plans of care" to care in (public or private) "institutions for mental diseases," but it mentions no examples.

HHS suggests that the term "public institution for mental diseases" may have a more restrictive meaning than simply a public "institution for mental diseases." *See* Defendant's Brief at 10 n.6. This idea is plausible, and if correct it could invalidate inferences from the meaning of "public institution for mental diseases" to the meaning of "institution for mental diseases." However, this idea is counterintuitive, and HHS does not support it.

C. *Legislative History*

Legislative history, by explaining the purpose behind the IMD exclusion, indicates a definition for "IMD." Further, by illuminating two of the three suggestive statutory sections just discussed, legislative history further supports this definition. Relevant legislation occurred in 1950, 1960, 1963, 1965, 1967, 1971, and 1972.[11]

1. *The Purpose of the IMD Exclusion*

The legislative history reveals two broad points. First, by the IMD exclusion, Congress meant to exclude state "mental hospitals" because the states were already funding them. Next, by a "mental hospital" Congress meant, at the least, a facility which provides total care to mental patients.

An IMD exclusion for Social Security was first enacted in 1950 for the old-age medical assistance program of Title I. 1950 Act, sec. 303, § 6, 64 Stat. at 549. This legislation

[11] I will refer to these acts as, *e.g.*, "the 1950 Act." The full citations for these seven acts, with their relevant provision summarized in parentheses, are:

1950: Social Security Act Amendments of 1950, Pub. L. No. 81-734, 64 Stat. 477, 549 (sec. 303, § 6, IMD exclusion for Title I).

1960: Social Security Amendments of 1960, Pub. L. No. 86-778, 74 Stat. 924, 991 (sec. 601, amending Title I IMD exclusion).

1963: Community Mental Health Centers Act of 1963, Title II of Pub. L. No. 88-164, 77 Stat. 282, 290-94 (funding construction of community mental health centers).

1965: Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286, 343-52 (sec. 121, enacted Title XIX, with IMD exclusion for those under age 65).

1967: Social Security Amendments of 1967, Pub. L. No. 90-248, 81 Stat. 821, 920 (sec. 250(a), § 1121, ICF coverage under Title XI).

1971: Pub. L. No. 92-223, 85 Stat. 802, 809 (sec. 4, § 1905, ICF coverage under Title XIX).

1972: Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, 1459-60 (sec. 295, clarifying coverage of ICF care in IMDs for those over 65).

Of these seven acts, the 1950, 1960 and 1967 Acts concern other Social Security titles; the 1963 Act does not concern Social Security; and the 1965, 1971 and 1972 Acts concern Social Security Title XIX.

provided for payment for medical care of individuals aged 65 or older in public and private institutions, excluding any individual "who is a patient in an institution for tuberculosis or mental diseases."[12] The House Committee on Ways and Means explained that the then current law permitted assistance to persons in private institutions but not those in public ones. However, the "needy aged persons who are chronically ill" could not find affordable private institutions for care. Federal payments for care in public institutions would encourage the admission of needy persons to existing public facilities as well as the development of additional public facilities. H.R. Rep. No. 1300, 81st Cong., 1st Sess. 42 (1949). The bill however excluded "assistance to persons residing in public or private institutions for mental illness and tuberculosis, since the States have generally provided for medical care of such cases." *Id.*

In 1965, Congress enacted the Medicaid program as Title XIX of the Social Security Act. This Title contains the provisions at issue in this case. Congress included in 1965 the same IMD exclusion that is now codified at 42 U.S.C. § 1396d(a)(B), quoted *supra* pp. 6-7. 1965 Act, sec. 121, § 1905(a)(B), 79 Stat. at 352. In contrast to the 1950 IMD exclusion (which applied in a title dealing only with individuals aged 65 and over), the 1965 IMD exclusion by its terms affected only individuals under age 65.[13]

---

[12] In the same sentence, the 1950 Act also excluded any individual "who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof." Benefits for such patients for up to 42 days were granted in 1960. 1960 Act, sec. 601(f), 74 Stat. at 991.

[13] Why did Congress single out the aged to receive IMD benefits? Apparently for two reasons. First, Congress had excluded IMDs in part because of the long-term care involved. But with the progress made in care for the mentally ill, care for the *aged* mentally ill was no longer much longer-term on the average than other care for the aged. Second, the line for old persons between mental illness and senility was hard to draw. Thus, an IMD exclusion would have posed a tough classification problem, and would also have discouraged appropriate patient transfer from one kind of facility to another. *See* Statement of Sen. Carlson, 110 Cong. Rec. 21349 (1964) (by implication).

HHS argues that Congress removed the IMD exclusion for those 65 and over *in order to fund alternatives to mental hospitals* in treating the aged

(footnote continues)

Congress excluded IMDs from funding because the states had traditionally funded care in mental hospitals. The Senate Finance Committee and the House Ways and Means Committee both stated that the "reason for this exclusion was that long-term care in such hospitals had traditionally been accepted as a responsibility of the States." S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 144, *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 2084; H.R. Rep. No. 213, 89th Cong., 1st Sess. 126 (1965).[14] Similarly, Secretary Celebreeze explained: "Under the bill, institutions providing care primarily for mental or tuberculosis patients are excluded from participation. The main reason for this exclusion is that most of these hospitals are public institutions and are supported by public funds. Nor did it seem reasonable to cover private but not public institutions." *Social Security; Medical Care for the Aged Amendments: Hearings on H.R. 11865 Before the Senate Comm. on Finance*, 88th Cong., 2d Sess. 108 (1964). *See also* House Comm. on Ways and Means, 89th Cong., 1st Sess., *Summary of Major Provisions of Medical Assistance for the Aged Program* 1 (Comm. Print 1965) ("The Federal Government does not

---

(footnote continued)

mentally ill. Thus, HHS concludes, Congress considered such alternative treatments as coming within the IMD exclusion. HHS points to the Senate Finance Committee report, Defendant's Brief at 15-16; however, the report does not support HHS' position. First, the report notes the increased treatment success, in mental hospitals and elsewhere, as a reason for considering mental illness on a par with physical illness. S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 144, *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 2084. Next, the report notes Congress' policy of encouraging alternative care, and explains that, as a condition to receiving funds for care for aged persons in IMDs, states are required to develop plans for use, when appropriate, of alternative care. *Id.* at 145, 1965 U.S. Code Cong. & Ad. News at 2085. Far from indicating that alternative care was before 1965 subject to the IMD exclusion, the report consistently contrasts "hospital," "institution," "institutional treatment," and "institutions for mental disease" on the one hand with alternative care on the other. *Id.* at 144-47, 1965 U.S. Code Cong. & Ad. News at 2084-87.

[14] The House version substituted "generally" for "traditionally."

In the quoted passage, the committees were describing the reasons for the IMD exclusion before 1965. However, in each case the committee was considering the 1965 IMD exclusion in the same light.

participate in respect to medical services furnished ... to patients in mental or tuberculosis hospitals.")[15]

Courts have echoed this interpretation of the 1965 IMD exclusion as referring to hospitals. A three-judge district court upheld the IMD exclusion against an equal protection challenge by finding a rational basis for the exclusion in Congress' "belief ... that care of the mentally ill in state hospitals was the responsibility of the states." *Legion* v. *Richardson*, 354 F.Supp. 456, 459 (S.D.N.Y.) (Stewart, J., joined by Feinberg, Cir. J., and Gurfein, J.), *aff'd sub nom. Legion* v. *Weinberger*, 414 U.S. 1058 (1973). In another equal protection case, the Supreme Court noted this policy behind the 1965 IMD exclusion to infer by analogy a rational basis for the exclusion of Title XVI Supplemental Security Income benefits from persons aged 21 through 64 residing in public mental institutions. *Schweiker* v. *Wilson*, 450 U.S. 221, 236-37 & n.19 (1981) (quoting *Legion* v. *Richardson* as well as "hospital" language in the Senate report).

[15] In contrast, state funding of alternatives to mental hospitals was most inadequate. In the early 1960's, alternatives to state mental hospitals were badly needed and not present in large quantity. H.R. Rep. No. 694, 88th Cong., 1st Sess., *reprinted in* 1963 U.S. Code Cong. & Ad. News 1054, 1064-65. Congress envisioned alternative care to come from "comprehensive community mental health centers" which would include "an emergency psychiatric unit, inpatient services, outpatient services, day and night care, foster home care, rehabilitation programs, and general diagnostic and evaluation services." *Id.*, 1963 U.S. Code Cong. & Ad. News at 1065. Such centers would "transfer the care of the mentally ill from State custodial institutions to community facilities and services comparable to the facilities and services provided at the community level for those who are physically ill." *Id.*, 1963 U.S. Code Cong. & Ad. News at 1058. In 1965, Congress still noted a strong need to provide more of such alternative care. S. Rep. No. 404, Part I., 89th Cong., 1st Sess. 145-47, *reprinted in* 1965 U.S. Code Cong. & Ad. News at 1943, 2085-86; H.R. Rep. No. 213, 89th Cong., 1st Sess. at 127-29 (1965). (Though in 1965 Congress was concerned specifically with the need for alternative care for aged mental patients, the committee reports fairly imply that Congress saw a need for more alternative care for mental patients in general.) Congress accordingly made the states adopt plans for alternative care of mental patients as a condition of funding for care to the aged in IMDs. 1965 Act, sec. 121, § 1902(a)(20), 79 Stat. at 347 (codified as amended at 42 U.S.C. § 1396(a)(20) (1976)); Statement of Sen. Long, 110 Cong. Rec. 21348 (1964). Therefore, Congress in 1965 had good reason to limit the IMD exclusion to "mental hospitals."

Just what did Congress mean by a "mental hospital"? Though Congress spoke of the long-term care given in hospitals for tuberculosis and mental illness, a facility apparently did not have to give long-term care in order to be an IMD. As mentioned above, the 1965 Act did not exclude IMD coverage for individuals aged 65 and over. In urging IMD coverage for such individuals, supporters of the bill interpreted the IMD exclusion as prohibiting payments for care even in hospitals which gave primarily short-term care. Statement of Sen. Ribicoff,[16] 111 Cong. Rec. 15801, 15805 (1965) (amendment was needed to remove the limitation on treatment for aged recipients "in mental or tuberculosis hospitals"; such limitation was reasonable only "based on the [outdated] assessment that the patients required long-term institutional care—which was a State responsibility"); *see* Statement of Sen. Carlson, 110 Cong. Rec. 21349 (1964) (asserting both that "[w]e have made great strides in the field of mental disease and in the field of tuberculosis" and that "we still prohibit long-term care and/or care in institutions specializing in these two diseases").

So long-term care was not a defining criterion of an IMD. Neither apparently was any particular level of psychiatric care. As late as 1965, Congress observed that many mental hospitals provided primarily custodial care rather than treatment leading to cure. *See* S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 147, *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 2086 ("there is great need for increased professional [mental health] services in hospitals"), and *id.* at 146, 1965 U.S. Code Cong. & Ad. News at 2086 (stressing need for states to move ahead with comprehensive mental health plans as contemplated in the 1963 Act, *in conjunction with* H.R. Rep. No. 694, 88th Cong., 1st Sess., *reprinted in* 1963 U.S. Code Cong. & Ad. News 1054, 1064 (considering the 1963 Act) ("Only a small percentage of the [state mental] institutions can be said to be therapeutic and not merely custodial."). Therefore, by "mental hospital" Congress did not have in mind any level of psychiatric care.

[16] Senator Ribicoff was a leading sponsor of the 1965 legislation, and a former HEW Secretary. Plaintiff's Brief at 13-14.

Though a "mental hospital" did not, in Congress' contemplation, have to provide long-term care or any particular level of psychiatric care, it did have to provide total care.[17] The term "hospital" connotes total care. Further, Congress' image of a state mental hospital was an institution which completely controlled the lives of its patients. H.R. Rep. No. 694, 88th Cong., 1st Sess., *reprinted in* 1963 U.S. Code Cong. & Ad. News 1054, 1064 (the state mental hospital, the treatment for most mentally ill patients, is the modern means for society to isolate, confine, and reject the mentally ill). Further, in 1971, when Congress added ICF coverage to Title XIX,[18] Congress contrasted the level of care of an ICF with that of a hospital. An ICF was defined as providing care beyond room and board but below that of a hospital or skilled nursing home. 1971 Act, sec. 4, § 1905, 85 Stat. at 809 (codified as amended at 42 U.S.C. § 1396d(c) (Supp. IV 1980), quoted *supra* p. 6). ICF care coverage was intended for persons who "in the absence of intermediate care would require placement in a skilled nursing home or mental hospital." Statement of Senate Finance Committee, printed in Statement of Sen. Long, 117 Cong. Rec. 44721 (1971).[19]

---

[17] The phrase "total care" is defined in note 9 *supra*.

[18] Congress had previously enacted ICF coverage for care for the aged, blind, and disabled under Title XI in 1967. 1967 Act, sec. 250(a), § 1121, 81 Stat. at 920.

[19] Similar statements accompanied earlier proposals to include ICF coverage under Medicaid. Senate Comm. on Finance, 92d Cong., 1st Sess., Material Related to H.R. 1—Medicare and Medicaid Amendments 48 (Comm. Print 1971); Statement of Sen. Long, 116 Cong. Rec. 41798, 41804 (1970).

As well as indicating that by "mental hospital" Congress meant a total care institution, this legislative history from 1970-1971 suggests on its own that an "IMD" cannot be defined, as HHS urges, as an institution primarily for mental patients. Indeed, since Congress intended ICF coverage for patients who otherwise "would require placement in a . . . mental hospital," it is unlikely then that Congress intended to exclude coverage in a facility which existed "primarily" for such persons.

So far, it appears that Congress meant the IMD exclusion to apply only to facilities providing total care to mental patients.[20] This interpretation answers the argument put forth by HHS that a state might transfer mental patients in large numbers from hospitals to ICFs such as Middletown Haven in order to increase federal cost sharing. Since ICFs provide less than total care, Congress did not intend to exclude coverage of their patients. Such transfers therefore would not violate Congress' purpose. Of course, only patients who do not need total care should be transferred. But the Secretary can mandate standards to that effect, 42 U.S.C. § 1396d(c) (Supp. IV 1981), and the state plans are already required to ensure that ICF patients are receiving enough care, 42 U.S.C. § 1396a(31) (1976).

2. *Various Sections Explained*

Legislative history, by illuminating two of the three suggestive statutory sections discussed *supra* pp. 9-11, further supports the interpretation of "IMD" as, at the least, a facility providing total care to mental patients. In the case of section 1396d(a), legislative history weakens arguments by HHS that an IMD cannot be just a mental hospital. In the case of section 1396a, legislative history strengthens and clarifies the inference that "community mental health centers" cannot be IMDs.

Section 1396d(a). In 1965, Congress covered inpatient hospital services and skilled nursing facility services by enacting parts (1) and (4) respectively of section 1396d(a). In 1971, Congress covered ICF services by enacting part (15) of this

---

[20] As just explained, a "mental hospital" need not provide long-term care, and it need not provide any particular level of psychiatric care; but it must provide total patient care. There may be further restrictions on what a "mental hospital" can be. A facility may need to have "enough" mental patients, in some sense, in order to be a "mental hospital." Further, it is possible that facilities with certain organizational structures cannot be IMDs. *See, e.g, infra* pp. 25-27 ("community mental health centers" are not IMDs). For the case at bar, it is not necessary to determine what restrictions there are on an IMD, beyond that it provide total care.

section. All three parts explicitly exclude coverage for "services in an institution for tuberculosis or mental diseases." HHS infers that, since ICFs and skilled nursing facilities may be IMDs, an "IMD" cannot be restricted to a mental hospital. However, these sections, simply read, speak to the case in which an inpatient hospital facility, skilled nursing facility, or intermediate care facility *may also happen to be* an IMD.[21] At least in the case of an ICF which is also an IMD, one facility would be giving *two different kinds of care* (total care and non-total care). For such a facility, *none* of the care would be covered.[22]

HHS argues that such a reading is strained, because it would require that "Congress' references to *e.g.*, intermediate care facility services [excluded as being provided in IMDs], is to a particular level of services provided *outside* a facility created to provide such service." Defendant's Brief at 11. However, the ICF services in question would not be provided outside an ICF; rather, they would be provided inside a facility that is both an ICF and an IMD.

Further, some legislative history of the 1971 Act supports this reading. Senator Bellmon explained that a skilled nursing facility might provide not only skilled nursing care but also intermediate (ICF) care. In that case, the ICF care given would qualify for reimbursement even though it was given in a skilled nursing facility. Statement of Sen. Bellmon, 117 Cong. Rec. 44720, 44721 (1971). Thus, at least in 1971, Congress

[21] The statute expressly allows that one facility may be both an ICF and a hospital. "The term 'intermediate care facility' also includes any skilled nursing facility or hospital which meets [various requirements of quality and patient protection]." 42 U.S.C. § 1396d(c) (Supp. IV 1980).

[22] HHS cites H.R. Rep. No. 231, 92d Cong., 2d Sess., *reprinted in* 1972 U.S. Code Cong. & Ad. News at 4989, 5097-98, for the proposition that "ICF care" cannot refer to care within a nursing home, and thus by analogy cannot refer to care within an IMD. Defendant's Brief at 13. However, the report cited simply warns against substandard nursing homes being passed off as ICFs, and notes that ICFs are not for patients who need full nursing care. The report nowhere implies that one facility may not give both ICF and nursing home care. In fact, Congress explicitly contemplated such an arrangement, Statement of Sen. Bellmon, 117 Cong. Rec. 44721 (1971), and the statute itself contemplates such an arrangement, *supra* note 21.

was considering the technical problem of coverage in one facility which gave two kinds of care. Therefore, it seems reasonable that in 1965 Congress took care to say that inpatient hospital services and skilled nursing facility services that happened to take place in a facility that was also an IMD were *not* covered, and that in 1971 Congress said further that ICF services that happened to take place in a facility that was also an IMD were *not* covered.

HHS points also to section 1396d(a)(14), which explicitly covers "inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases." Again, it seems to HHS that this section reads unnaturally if an IMD is a mental hospital. Defendant's Brief at 12. However, since the section simply restores to those over 65 the coverage in IMDs for three particular services which was generally excluded in the sections discussed above, the section does not seem at all unnatural.[23]

Congress enacted this section in the 1972 Act, sec. 297, 86 Stat. at 1459-60. Because inpatient hospital services, skilled nursing facility services, and intermediate care facility services were already covered by sections 1396d(a)(1), (4), (15), and the IMD exclusion in those sections and in section 1396d(a)(B) applied only to those under 65, section 1396d(a)(14) was not strictly necessary. It was added rather for clarity, especially to make clear that the unusual situation of an IMD giving ICF services for someone 65 or over was covered. S. Rep. No. 1230, 92d Cong., 2d Sess. 321 (1972).

[23] HHS argues that, if an IMD were a mental hospital, then the term "hospital" would be superfluous, and Congress would instead have referred to "simply 'all services, including SNF and ICF services, provided in an IMD.'" Defendant's Brief at 12. However, the wording which Congress chose seems, if anything, simpler than HHS' proposed wording. Congress' wording also reads more easily because it better tracks the rest of the statute.

HHS points to a conference report which describes the provision as providing that "when a State chooses to cover individuals age 65 and over in institutions for . . . mental diseases it must cover such care in intermediate care facilities as well as in hospitals and skilled nursing homes." H.R. Rep. No. 1605 (Conference Report), 92d Cong., 2d Sess. 65, *reprinted in* 1972 U.S. Code Cong. & Ad. News 5370, 5397. This report seems to consider that institutions for mental disease may as a regular matter be hospitals, nursing homes, and intermediate care facilities. HHS thus argues that an IMD cannot be limited to a mental hospital. Defendant's Brief at 13. However, this conference report is confused. The report improperly states that the provision *requires* coverage of ICF services in IMDs if a state covers hospital and skilled nursing home services in IMDs, when such coverage is optional, *see* 42 U.S.C. § 1396a(13) (1976 & Supp. IV 1980). Further, though the amendment only applies to Medicaid, the report titles it as applying to "Medicare." The conference report considered this amendment very briefly, and it dealt with many amendments, all in a year-end rush, Plaintiff's Reply Brief at 11 n.3. The report is thus not persuasive on this technical point.

Section 1396a. Section 1396a(21) gives "community mental health centers" as an example of an alternative to "public institutions for mental diseases." It was noted, *supra* p. 11, that this language, while suggesting that Middletown Haven is not an IMD, is not conclusive for two reasons. First, "community mental health center" is undefined. Second, Congress in this section may have contemplated community mental health centers as privately run; in that case, they would be alternatives to "public institutions for mental disease" simply because they were private, not because they were not institutions for mental disease. Legislative history speaks to both of these questions, establishing that a community health center is not an IMD and clarifying what a community mental health center is.

A good source of what Congress meant by "community mental health centers" in 1965 is the Community Mental

Health Centers Act of 1963.[24] In the 1963 Act, Congress envisioned community mental centers as follows:

> The patient services included in such a center would include an emergency psychiatric unit, inpatient services, outpatient services, day and night care, foster home care, rehabilitation programs, and general diagnostic and evaluation services. In addition, the center would offer consultative services to other community agencies and organizations such as information programs in schools and through other public and private agencies.
>
> The community mental health center would build on and be a part of the existing resources and programs of the community—public and private—rather than be isolated from them. For example, the psychiatric ward of a general hospital would be the major focus of the center in many communities. Existing outpatient mental health clinics might also form the nucleus of a center. Each community would have a major voice in determining the basic pattern of services to be offered through its own mental health center.

H.R. Rep. No. 694, 88th Cong., 1st Sess., *reprinted in* 1963 U.S. Code Cong. & Ad. News 1054, 1065-66. Since community mental health centers could "build on and be a part of . . . public and private" resources, Congress apparently envisioned them as quite free to be either public or private. Thus, in section 1396a(21) Congress did imply that community mental

---

[24] Indeed, the 1963 Act's program for community mental health centers was still very much on Congress' mind as it considered the 1965 Act. In fact, Congress saw sections 1396a(20)-(21) as helping to carry out the 1963 Act's program. S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 146, *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 2086 (stressing need for states to move ahead with comprehensive mental health plans as contemplated in the 1963 Act).

health centers (which may indeed be public) are not "institutions for mental disease."[25]

The quotation above characterizes community mental health centers in terms of the range of services provided, the community-based resources used, and the community's voice in the center's control. Section 1396a(21) strongly suggests that *an establishment meeting this description is not an IMD*. This italicized proposition could be considered largely as an example of the more general proposition that an IMD must provide total care. Indeed, of the various services listed for a community mental health center to provide, only one, "inpatient services," involves total care.[26] This proposition does however suggest other limits on what an IMD can be. For this case, we need not discuss these limits.[27] At any rate, the italicized proposition above cuts directly against HHS' position that any institution maintained primarily for mental patients is an IMD.

D. *Conclusion*

At first glance, the term "institution for mental diseases" (IMD) is quite uncertain in meaning. The legislative history behind the enactment in 1965 of the IMD exclusion in section 1396d(a)(B) indicates that an IMD is a "mental hospital." Further legislative history reveals that a "mental hospital" means, at the least, a facility which provides total care to mental patients.

---

[25] Further, the legislative history of the 1965 Act itself supports the view that community health centers were an alternative to public *and* private institutions for mental disease. The Senate committee report mentioned community mental health centers as an alternative to "mental hospitals," S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 146, *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 2086, which in turn the committee was using as a synonym for "institutions for mental diseases," *see id.* at 144-47, 1965 U.S. Code Cong. & Ad. News at 2084-87.

[26] If a community mental health center did offer some services in a mental hospital setting, those services would, notwithstanding section 1396a(21), be excluded from coverage as occurring in an IMD. However, other services offered by the community mental health center need not be therefore tainted. Section 1396d(a)(15), which provides coverage for "intermediate care facility services (other than such services in an institution for mental diseases)," might still cover ICF services given by the community mental health center if they were given in a physically separate facility. *Cf.* § 1396d(c) (considering the character of a "distinct part" of an institution).

[27] *See supra* note 20.

Other sections of the Medicaid statute, viewed together with legislative history, support this interpretation of "IMD." Section 1396d(c), by suggesting equal treatment of mental and physical conditions, favors this interpretation because it discriminates less effectively against mental patients than does an interpretation, as proposed by HHS, based solely on whether the institution is maintained primarily for mental patients. Section 1396a(20) implies that a "community mental health center" is not an IMD. Section 1396d(a), parts (1), (4) and (15), which exclude care in IMDs from certain covered care, and part (14), which specifically includes these same types of care in IMDs for persons aged 65 or over, do not read unnaturally with this interpretation of "IMD."

Therefore, I hold that an IMD is a mental hospital, which in turn means, at the least, a facility which provides total care to mental patients.

VI. DEFERENCE TO HHS

HHS asserts that its regulations interpreting the statute deserve deference.[28] The parties argue back and forth about whether HHS' regulations and practice have been clear and longstanding. That argument need not be considered, for even a clear, longstanding agency interpretation would not deserve deference here. The reason is that the statutory construction at issue involves not technical details but the statute's broad purpose. While agencies are expert at the former, courts are expert at the latter.[29]

---

[28] HHS cites *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 44 (1981). In that case, Congress had "explicitly delegated to the Secretary broad authority to promulgate regulations defining eligibility requirements for Medicaid." *Id.* at 43. No such explicit delegation exists in the case at bar.

[29] HHS also argues that Congress, by amending the Medicaid provisions without further defining "IMD," silently approved HHS' definition. Defendant's Reply Brief at 5-6. This argument depends not on deference to HHS but on inferring Congress' intent from silence. The force of this argument depends on what HHS did (*see, e.g.*, Defendant's Brief at 19, arguing that regulations supporting HHS' position have been in effect since 1966) and how Congress reacted (*see, e.g., supra* note 19, implying that Congress in 1971 did not approve HHS' position). In any event, this argument, being merely one based on silence, would not overcome the clear indications discussed above that Congress had a different definition in mind.

Judge Friendly discussed the issue of deference to administrative interpretations of statutes in *Pittson Stevedoring Corp.* v. *Dellaventura*, 544 F.2d 35 (2d Cir. 1976), *aff'd sub nom. Northeast Marine Terminal Co.* v. *Caputo*, 432 U.S. 249 (1977). At issue was whether the 1972 amendments to the Longshoremen's and Harbor Workers' Compensation Act could cover workers while engaged in stuffing and stripping containers on shore. In affirming the agency's holding of coverage, the court relied on its own statutory interpretation rather than on deference to the agency. *Id.* at 51-56. In declining to rely on deference to the agency, Judge Friendly noted that there are two conflicting lines of Supreme Court authority regarding deference to agencies on issues of statutory interpretation. One line "support[s] the view that great deference must be given to the decisions of an administrative agency applying a statute to the facts and that such decisions can be reversed only if without rational basis." The other line "sanction[s] free substitution of judicial for administrative judgment when the question involves the meaning of a statutory term." *Id.* at 49. From this second line, Judge Friendly singled out *Morton* v. *Ruiz*, 415 U.S. 199, 237 (1974), in which the Supreme Court held that "In order for an agency interpretation to be granted deference, it must be consistent with the congressional purpose." Judge Friendly noted that this holding "very nearly eliminates the 'deference' principle as regards statutory construction altogether since if the agency's determination is found by a court to be consistent with the congressional purpose, it presumably would be affirmed on that ground without any need for deference." 544 F.2d at 49.

In fact, even the line of Supreme Court cases supporting deference is perfectly consistent with independent judicial determination of a statute's broad purpose. One case in this line is *NLRB* v. *Hearst Publications, Inc.*, 322 U.S. 111 (1944). At issue there was whether newsboys were "employees" under the National Labor Relations Act. Without even pausing to justify doing so, the Court interpreted the purpose of the Act. The Act aimed to "bring industrial peace by substituting, so far as its power could reach, the rights of workers to self-

organization and collective bargaining for the industrial strife which prevails where these rights are not effectively established." *Id.* at 125. The Act tried to correct "the inability of individual workers to bargain successfully for improvements in their 'wages, hours, or other working conditions' with employers who are 'organized in the corporate or other forms of ownership association.' " *Id.* at 126. The Court concluded that an economically inferior party, having need of the Act's protection, could be an employee for the purposes of the Act even if at common law he would be instead an independent contractor. *Id.* at 126-29. The Court so interpreted the statute with no mention of the NLRB. Only then did the Court defer to the Board's finding, based on the details of the work situation involved, that certain newsboys were employees. The Board's discretion was allowed only within the framework of the Court's interpretation. "Determination of 'where all the conditions of the relation require protection' involves inquiries for the Board charged with this duty." *Id.* at 130.

Another case in this line, *Gray* v. *Powell*, 314 U.S. 402 (1941), contains a similar analysis. The Bituminous Coal Act regulated coal marketing but exempted coal consumed by the producer. *Id.* at 410-11. At issue was the scope of this exemption. The Court first determined on its own that the Act's purpose required looking behind nominal ownership to real economic identity, and then deferred to the agency on the details of how to determine such economic identity. The Court held:

> The separation of production and consumption is complete when a buyer obtains supplies from a seller totally free from buyer connection. Their identity is undoubted when the consumer extracts coal from its own land with its own employees. Between the two extremes are the innumerable variations that bring the arrangements closer to one pole or the other of the range between exemption and inclusion. To determine upon which side of the median line the particular instance falls

> calls for the expert, experienced judgment of those familiar with the industry.

Id. at 413.[30]

This distinction between interpreting a statute's broad purpose on the one hand, and effecting technical classifications pursuant to that purpose on the other, finds strong support from Professor Kenneth Culp Davis. According to Professor Davis, underneath the complex rhetoric, courts in the main act as follows:

> *In absence of a particular statute otherwise providing, courts avoid substitution of judgment for that of the agencies on all questions except the kind of questions of law about which courts are generally better qualified than agencies . . . .*

K. Davis, *Administrative Law Treatise* ¶ 29.00-1 at 520 (Supp. 1982) (emphasis in original).[31] Generally, courts better than agencies can determine the broad purpose behind a statute. Courts are skilled in examining statutory language and legislative history to determine Congress' purpose. Courts are also free of a narrow view which may taint agencies. Further, technical agency expertise is of little value in ascertaining the statute's broad purpose. On the other hand, determining the best technical implementation of policy, including how to categorize borderline cases, is generally done better by agencies with technical expertise. The same point runs through most of the commentaries excerpted in W. Gellhorn, C. Byse & P. Strauss, *Administrative Law—Cases and Comments* 309-18 (7th ed. 1979).

In the case at bar, the basic issue discussed above has been one of broad statutory construction: what was Congress' purpose behind the IMD exclusion? By examining statutory language and legislative history, I found that Congress meant to

[30] *NLRB* v. *Hearst* and *Gray* v. *Powell* are analyzed in this way in Nathanson, *Administrative Discretion in the Interpretation of Statutes*, 3 Vand. L. Rev. 470, 472-75 (1950).

[31] Professor Davis is discussing "Scope of Review of Informal Action Including Rulemaking." The vast bulk of agency action, including the regulations at issue here, is "informal" as that word is technically used.

exclude mental hospitals, meaning, at the least, facilities which provide total care to mental patients. Fine determinations of what constitutes total care are proper subjects for administrative expertise, but not the basic determination above.

VII. CONCLUSION

The IMD exclusion in 42 U.S.C. § 1316d(a) (part of the Medicare program, Title XIX of the Social Security Act) excludes only care in mental hospitals, meaning care in facilities which, at the least, provide total care to mental patients. This interpretation is based on this court's independent review of the statute's language and legislative history, without deference to HHS' contrary interpretation, even though HHS' interpretation may have been longstanding.

Accordingly, the Secretary's decision that Middletown Haven Rest Home is an IMD was based on improper factors. Specifically, the Secretary did not determine that Middletown Haven provided total care to mental patients. Accordingly, the Secretary's decision was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" within the meaning of APA section 706(2)(A), 5 U.S.C. § 706(2)(A) (1976). *Citizens to Preserve Overton Park* v. *Volpe*, 401 U.S. 402, 416, 420 (1971). The Secretary's decision is accordingly reversed and remanded to HHS.

As HHS' determination has been reversed, HHS has now no claim against Connecticut based on the funds which HHS had disallowed (though a claim may arise in the future if HHS disallows the funds on proper grounds). This court trusts that HHS accordingly will assert no setoff, and will promptly restore any setoff already taken. An injunction is therefore unnecessary.

SO ORDERED.

Dated at Hartford, Connecticut, this 17th day of February, 1983.

M. JOSEPH BLUMENFELD
Senior United States District Judge

APPENDIX D

DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

Subject: Joint Consideration: Date: November 30, 1981

"Institutions for Mental Diseases"

Docket Nos. 79-52-MN-HC
79-89-MN-HC
80-44-IL-HC
80-150-CT-HC
80-184-CA-HC

Decision No. 231

DECISION

The Board jointly considered five appeals by four different States (Minnesota, Illinois, Connecticut, and California), raising common issues of law and some common issues of fact. Each appeal was from a determination by the Health Care Financing Administration (Agency), disallowing Federal financial participation (FFP) claimed by a State under Title XIX (Medicaid) of the Social Security Act for services provided in a private facility certified by that State as a skilled nursing facility (SNF) or intermediate care facility (ICF). The Agency determined that the facilities were "institutions for mental diseases" and, therefore, FFP was not available under Medicaid for services provided by the facilities to individuals under age 65.

Our decision is based on the States' applications for review; the Agency's responses to the separate appeals; pre-hearing briefing submitted by the State of Connecticut; the transcript of a hearing held before the full Panel on April 22 and 23, 1981, involving all four States; exhibits submitted at the hearing; the Agency's consolidated brief, filed after the hearing; and the States' reply briefs. Although no party objected to joint consideration and, in fact, each State chose to rely on oral

presentations by other States on various issues, each State was given a full opportunity to present its individual case.

Because of the complexity of the issues raised, and the number of parties and facilities involved, we have first briefly summarized our decision (Section I). We then present a more detailed analysis of the parties' arguments, divided into three major sections: issues related to the relevant statutory provisions and their legislative history (Section II); issues related to pertinent regulations (Section III); and issues related to certain Agency "Criteria" for applying the regulations (Section IV). Finally, we discuss the factual issues raised by specific States (Section V).

I. Summary of Decision

Under Title XIX of the Social Security Act (Act), FFP is not available for certain services provided to any person under 65 who is a patient in an "institution for mental diseases" (IMD). The Act does not define this term. Agency regulations provide that an IMD is an institution "primarily engaged in providing diagnosis, treatment or care of persons with mental diseases," and that whether a particular facility is an IMD is determined by its "overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases." The Agency used unpublished supplementary criteria in applying the regulation.

Briefly, the Agency determined that high percentages of the patients in the SNFs and ICFs had mental diseases; that most of the facilities held themselves out as caring for the mentally ill; that some of the facilities had special programs designed specifically for the mentally ill; and that each facility had other characteristics of an IMD under the regulations.

The States did not challenge the validity of the Agency regulations. Rather, the States argued based on their reading of the Act and its history, and on their reading of the regulations, that the IMD exclusion should be interpreted to cover only the traditional mental hospital or its equivalent, not the SNFs and ICFs here. The States challenged the use of the Agency's

supplementary criteria, arguing that the criteria were not properly published and, in any event, are flawed and were erroneously applied. In particular, the States attacked the Agency approach of counting patients with mental disorders in the facilities.

Our determinations, discussed in detail below, are as follows:

- The Agency's regulations reflect a reasonable interpretation of the Act and its legislative history, and were clear enough to put the States on notice that facilities such as these SNFs and ICFs are IMDs.
- There is persuasive evidence, by any reasonable standard, to show that the "overall character" of the facilities in question was that of institutions established and maintained primarily for the care and treatment of persons with mental diseases.
- Lack of publication of the criteria does not provide a basis for reversing the disallowances here, since these facilities were IMDs under any reasonable reading of the regulations.
- Although some of the Agency's findings developed through using the criteria carry less weight or represent some inconsistency in applying the criteria, these defects do not invalidate the Agency's findings as a whole.

Based on these findings and conclusions, we have upheld the disallowances.

In doing so, we are mindful that the dispute is, in large part, a consequence of the absence of explicit Congressional guidance in the face of changing circumstances in the care of the mentally ill. Neither side is supported definitively by the Act or its legislative history, and there are countervailing policy considerations involved: the disincentive that these disallowances might provide for the principle of deinstitutionalization of the mentally ill, and the concern of the Agency that States might inappropriately move patients out of mental hospitals into SNFs or ICFs to maximize FFP. But whether or

not the law or the regulations should be changed are policy questions beyond the authority of this Board. Our decision essentially is that the Agency's rules, reflecting a reasonable interpretation of the statute, were fairly applied here and that there is substantial evidence in the record to support the conclusion that these facilities were IMDs.

II. The Statute and Legislative History

The major issue raised by the States is whether the statutory language, read in light of the legislative history of the IMD exclusion, compels a reading of the statute and regulations under which the exclusion applies only to institutions which are similar to, or the functional equivalent of, mental hospitals. Stated differently, the issue is whether the Agency application of the statute and regulations to the private, free-standing SNFs and ICFs here is consistent with legislative intent. For the reasons discussed below, we conclude that the Agency interpretation is supported by the language of the statute and that the legislative history does not compel a different reading.

Our discussion of this issue is divided into three parts: the history of development of the IMD exclusion and relevant provisions from Title XIX; a statement of the parties' arguments on this issue; and our analysis of the arguments.

A. Development of the Statutory Exclusion

The Social Security Act Amendments of 1950, Pub. L. 81-734, contained the original IMD exclusion. Those amendments defined "old age assistance," under Title I of the Act, to include payments to residents of most public medical institutions but to exclude "payments to or care in behalf of . . . any individual (a) who is a patient in an institution for tuberculosis or mental diseases, or (b) who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof." Section 6 of the Act.[1]

[1] The relevant House Report states: "Your committee does not favor Federal participation in assistance to persons residing in *public or private* institutions for mental illness . . . , sipce the States have generally provided for medical care of such cases." H.R.Rep. 1300, 81st. Cong., 1st Sess. 42 (1949). (Emphasis added.)

When "medical assistance" for the aged was added in 1960, Pub. L. 86-778, that term was similarly defined to exclude payments with respect to long-term "care or services for . . . any individual who is a patient in an institution for . . . mental diseases . . . ." Section 6(b).

The Social Security Act Amendments of 1965, Pub. L. 89-97, removed prohibitions on funding for the mentally ill in a general hospital and provided for the first time for medical assistance on behalf of individuals 65 years of age or older who were patients in IMDs. To receive Federal funding for such assistance, however, States had to have programs which met certain standards. Conditions included "the development of alternate plans of care . . . for recipients 65 years of age or older who would otherwise need care in such institutions" and "assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care." If a State plan included such assistance to patients in public institutions for mental diseases, the State had to show that it was making "satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing homes, and other alternatives to care in public [IMDs]."[2]

The House Report on the 1965 Amendments referred to "payments to, or for, patients in mental hospitals . . . ." H.R.Rep. No. 213, 98th Cong., 1st Sess. 19 (1965). The exclusion was explained (at 126) as relating to patients in public or private mental hospitals since "long-term care in such

[2] These provisions were originally proposed as amendments to Titles I (Old-Age Assistance and Medical Assistance for the Aged) and XVI of the Act. Identical provisions were incorporated into Title XIX at Sections 1902(a)(20) and (21). The provisions were promoted on the Senate floor by Senator Carlson who spoke of "great strides in the field of mental disease," stating that he was "convinced that the time has come that these diseases should no longer be set apart from others . . . ." He also referred to the need for greater flexibility in care of the aged than in other age groups, since it is difficult to determine whether an elderly person is mentally ill or merely senile, and "it may be appropriate for him at one time to be in a mental institution and at another to be in a nursing home, his own home, or in some other arrangement." 110 Cong. Rec. 21349 (1964).

hospitals had generally been accepted as a responsibility of the States." The term "hospital" was used in the report to explain removal of the exclusion and "nursing homes" were referred to as an alternative to care in such hospitals.[3]

In Title XIX of the Act, also enacted in 1965, the exclusion appears in the general definition of "medical assistance" for which FFP is available, as well as in conjunction with various levels of services. Section 1905(a) currently defines "medical assistance" as—

> payment of part or all of the cost of the following care and services . . .
>
> (1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);
>
> • • •
>
> (4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) . . . ;
>
> • • •
>
> (14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;
>
> (15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) . . . ;
>
> • • •
>
> except as otherwise provided in paragraph (16), such term does not include—
>
> (A) any such payments with respect to care or services for any individual who is an inmate of a public

[3] Similar language appears in the Senate Report. S.Rep. No. 404, Part I, 89th Cong., 1st Sess. 144-47 (1965). See also, Statement of Senator Ribicoff, 111 Cong. Rec. 15801 (1965).

> institution (except as a patient in a medical institution); or
>
> (B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in any institution for tuberculosis or mental diseases.

For purposes of Title XIX, the term "intermediate care facility" is defined as—

> an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities . . . . Section 1905(c).[4]

The provisions for coverage of ICF services were added by the Social Security Act Amendments of 1972. These Amendments also added paragraph (16) to Section 1905(a), including as "medical assistance" under certain conditions "inpatient psychiatric hospital services for individuals under 21 . . . ." The conditions for coverage included that the institution in which the services were provided be "accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals" and that the services involve "active treatment" which could reasonably be expected to improve the patient's condition. Section 1905(h)(1).[5]

[4] This section further provides, "With respect to services furnished to individuals under age 65, the term 'intermediate care facility' shall not include, except as provided in subsection (d), any public institution or distinct part thereof for mental diseases or defects." Subsection (d) provides that, under certain conditions, ICF services may include services in "a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions . . . ."

[5] A Finance Committee amendment which would have also authorized funding of demonstration projects to determine the "potential benefits of extending medicaid coverage to mentally ill persons between the ages of 21 and 65," S.Rep. No. 1230, 92d Cong., 2d Sess. 57 (1972), was dropped in conference, H.R.Rep. No. 65, 92d Cong., 2d Sess. 65 (1972).

B. The Parties' Arguments on Legislative Intent

The States' position is that "Congress intended the term 'institution for mental diseases' to apply only to mental hospitals, which were the facilities traditionally used by states to care for the mentally ill." Brief of the State of Connecticut (CT Br.), p. 3.[6] Under the States' interpretation SNF or ICF services would be excluded only if provided in a State mental hospital or the functional equivalent.

The Agency position is that SNF or ICF services are excluded if they are provided in any institution which meets the regulatory definition. Such an institution could be a private facility and it need not be part of or on the grounds of a mental hospital; the basic requirement is that the institution's overall character must be that of a facility established and maintained primarily for individuals with mental diseases.

For their position, the States rely primarily on the references to "mental hospitals" in the legislative history cited above and on several court opinions which refer to the exclusion. The States cite to language in the Supreme Court case of *Schweiker* v. *Wilson*, 450 U.S. 221 (1980),[7] and to similar statements in two other cases,[8] in support of their view that "it was the large

[6] See also, Post-Hearing Reply Brief of State of California (CA Reply Br.), p. 2 (relating the exclusion to "the traditional state mental hospital or the functional equivalent thereof").

[7] In that case, the Court related the IMD exclusion to Congress' assumption that the care of persons in public mental institutions was properly a responsibility of the States, citing for this conclusion the legislative history reference to "long-term care in such hospitals . . . ." 450 U.S. at 237, n. 19. The States also rely on the following statement in the dissent in *Schweiker*: "The residual exclusion of large state institutions for the mentally ill from federal financial assistance rests on two related principles: States traditionally have assumed the burdens of administering this form of care, and the federal government has long distrusted the economic and therapeutic efficiency of large mental institutions." See S. Rep. No. 404, 98th Cong., 1st Sess., 20 (1965), reprinted in 1965 U.S. Code Cong. & Admin. News 1943, 2084." 450 U.S. at 242.

[8] *Legion* v. *Richardson*, 354 F. Supp. 456 (S.D.N.Y.), *aff'd sub nom.*, *Legion* v. *Weinberger*, 414 U.S. 1058 (1973), and *Kantrowitz* v. *Weinberger*, 388 F. Supp. 1127, 1130 (D.D.C. 1974), *aff'd* 530 F.2d 1034 (D.C.Cir), *cert. denied*, 429 U.S. 819 (1976).

state-financed mental hospitals, which provided primarily custodial care, that Congress meant to exclude," not SNFs and ICFs. CT Br., pp. 19-20. The States argue that SNFs and ICFs were developed as alternatives to care in traditional institutions, as shown by the statutory provisions and legislative history associated with the 1965 Amendments. Since use of nursing homes was encouraged by Congress as part of the process of "deinstitutionalization," the States contend, these SNFs and ICFs cannot themselves be the type of institutions which Congress refused to fund.

The Agency responds that "although the statute does not specifically state that a SNF or an ICF can be an IMD, such an interpretation is the only reasonable one . . . ." Consolidated Response of the Health Care Financing Administration to the States' Applications for Review (Cons. Br.), p. 31. The Agency relies primarily on the language of the Act, particularly Section 1905(a). The scheme of that section, as a whole, the Agency argues, supports the position that hospitals do not occupy some special status. Cons. Br., p. 36. Since that section lists hospital services separately from SNF and ICF services, and excludes each type of service in an IMD, the section must be read so that an SNF or ICF can be an IMD, the Agency contends.

Citing Section 1905(a)(14), the Agency argues:

> Acceptance of the States' argument that an IMD can only be a hospital, in effect, makes superfluous the term "hospital" in this provision since it presumably was the same as, and was already included, within the term IMD. If this was the intent, the provision would have stated simply "all services, including SNF and ICF services provided in an IMD." It was not so drafted and as a result the terms hospital, SNF, and ICF services must be interpreted consistently to permit any of these institutions to be IMDs. Cons. Br., p. 33.

The States counter that the term "hospital" in the legislative history was not intended to refer merely to a level of care (acute care), like the term "hospital" in the Act itself. Rather, the States argue, Congress used the term in the legislative

history to refer to "a 'total institution' setting, that is, a place where all the patients' needs were met by the facility." CA Reply Br., pp. 6-7; see also CT Br., p. 20, n.2. Since this kind of institution might offer different levels of care, the States argue, Congress needed to refer to all three levels to effect a complete exclusion of all services provided by the institution. See, e.g., CT Br., p. 20, n. 1; CT Reply Br., p. 4. The States argue that, since section 1905(a) refers to services *in* an IMD, the section can reasonably be read to mean merely that no level of services can be provided to persons under 65 in a mental hospital. CA Reply Br., p. 8.

The Agency responds that the States' interpretation is not logical because, under it, an institution could never be an IMD, "even if the institution provided solely psychiatric services at a SNF level of care to 100% of its patients. . . ." Cons. Br., p. 37.

An additional State argument, related solely to ICFs, is based primarily on the statutory definition of an ICF at Section 1905(c). This section refers to ICFs providing "care and services to individuals who . . . because of their *mental* or physical *condition* require care and services . . . ." (Emphasis added.) The States argue, "It would be wholly inconsistent with this explicit statutory language to remove Medicaid coverage for an ICF simply because some percentage of the residents have been placed there because of a mental condition." CT Reply Br., p. 18. The States also point to legislative history which states that ICF coverage is for persons "who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital." CT Reply Br., p. 19, citing 117 Cong. Rec. 44721 (1971).[9] This shows, the States argue, that Congress intended Medicaid to cover those individuals in ICFs who otherwise would have been in a mental hospital.

[9] The legislative history refers to intermediate care as "for persons with health-related conditions who require care beyond residential care or boarding home care, and who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital." Statement of Senator Bellmon, 117 Cong. Rec. 44720 (1971).

The States argue, in addition, that applying the IMD exclusion to SNFs and ICFs contravenes Congress' intent in other respects. The States point out that the Agency approach can result in denial of Medicaid coverage to all individuals under 65 in an IMD, regardless of diagnosis. Such denial, the States contend, "seems consistent with congressional intent only where mental hospitals are involved, since all residents of such hospitals presumably are mentally ill." CT Br., p. 21.

The States also find the Agency interpretation to be inconsistent with statutory and regulatory prohibitions against discrimination on the basis of diagnosis. We discuss this question below in connection with the Agency's counting of patients with diagnoses of mental disorders in the facilities.

C. Discussion of the Legislative Issues

Both parties have recognized here that not all of the provisions of the statute or the legislative history can be reconciled with either party's position. As the States point out, "The statute is not easy to parse," Tr., p. 29, and, as the Agency acknowledges, "With regard to the legislative history of the terms 'IMD' and 'institutions,' no clear definitions are evident . . . ." Cons. Br., p. 37. We conclude below however, that the Agency interpretation is supported by the language of the statute itself and consistent with the legislative history.

The States acknowledge that a private mental hospital, if traditionally used by a State for care of its mentally ill, could be an IMD and could be providing SNF or ICF services. See, e.g., Tr., pp. 115 and 118. This result is compelled by the statutory language, especially viewed in light of its history and context. Although used elsewhere in the statute, the modifier "public" is notably absent from the term "institution for mental diseases."[10]

The statute is less clear on the issue of whether the IMD exclusion encompasses private SNFs and ICFs of the type

[10] In Section 1905(a), following paragraph (17), the exclusion for a patient in an IMD appears after a general exclusion for "an inmate of a public institution (except as a patient in a medical institution)." Also, in establishing conditions for States wishing to include coverage of patients 65 or over in IMDs, the statute requires different State plan provisions for such assistance "in institutions for mental diseases," Section 1903(a)(20), and for such assistance "in public institutions for mental diseases," Section 1902(a)(21). See also, the legislative history cited in footnote 1 above.

under consideration here. In using the term "institution for mental diseases" without definition, however, Congress can reasonably be assumed to have given the Agency leeway in determining what institutions would be excluded. Certainly, the term is not specifically limited to "traditional facilities" or to "large, warehouselike facilities" or to accredited psychiatric hospitals.

Further, the structure of Section 1905(a) supports the Agency position. The exclusion appears in reference to each specific level of care: hospital, SNF, and ICF. Although the States' explanation of this is not as "totally illogical" as the Agency says it is, the Agency interpretation that Congress meant to exclude each level of care, regardless of whether a facility encompasses only one or all three levels, makes more sense.

Moreover, we do not agree with the States that the legislative history compels the conclusion that Congress intended that the exclusion never apply to a private, free-standing SNF or ICF. The question simply is not addressed.

Although the legislative history is replete with references to "mental hospitals," there are several factors which make these references less meaningful in resolving the issue with which we are confronted.

As the States themselves point out, the term "hospital" is used differently in the legislative history than in the statute. The record indicates that, at the time the exclusion was originally enacted, a so-called mental hospital was most likely providing only custodial care and would not have qualified as an acute care hospital for Medicaid purposes. Therefore, we do not think that reference to mental hospitals as IMDs in the legislative history precludes a broader interpretation of the statutory term IMD.[11] This is particularly true in light of the change in circumstances from the time when the exclusion was

[11] Also, the use of the phrase "*in* an institution for mental disease" with respect to the various levels of services in Section 1905(a) does not necessarily imply that the services are provided by a facility that is part of a larger institution. SNF services, for example, are provided *in* an SNF and therefore would be *in* an institution whether the SNF is an institution itself or a distinct part of a larger institution.

enacted to the present. Congress may not have contemplated that the States would use private SNFs or ICFs to fulfill the role that State mental hospitals had traditionally fulfilled, but neither did it state that this could not be so.

Moreover, given that the term "mental hospital" in the legislative history is not defined, and means something different than an institution meeting Medicaid hospital standards, even if we were to substitute this term for the statutory one of "institution for mental diseases" we would be left with an amorphous concept. The States have not clearly delineated a difference between the "traditional mental hospital," providing primarily custodial care, and these facilities here.

The statutory language and legislative history on which the States rely most heavily is related to the 1965 provisions permitting State plans to cover IMD services for the aged. Considered in context, however, the statements are not inconsistent with the Agency position. Section 1902(a)(21) of the Act does refer to nursing homes as an alternative form of care. This section deals, however, solely with *public* IMDs and nursing homes as an alternative to care in public IMDs.

In Section 1902(a)(20), which is not limited to public IMDs, nursing homes are not specifically mentioned as an alternative.[12] The States' reliance on the phrase "readmittance to institutions where needed under alternate plans of care" in this section is also misplaced. As shown by the legislative history, alternate plans can include care in community mental health centers or the patients' own homes. From these alternate plans, readmittance conceivably could include readmittance to an institution which was a nursing home.

Further, the term "institution for mental diseases" for purposes of coverage for the aged is narrower in scope than the definition related to the general exclusion. Under implementing regulations now at 42 CFR § 440.140, to be qualified

[12] To a certain extent, the States' arguments based on these provisions have the same flaw which the States identify with respect to some Agency arguments on the sections. See, CT Reply Br., p. 3, n. 1. Both parties refer to the conditions for coverage as though those conditions determined the scope of the exclusion.

to carry out the provisions of the Act with respect to services to aged recipients, an "institution for mental diseases" must meet general requirements for a psychiatric hospital under Section 1861(f) of the Act.[13] Given this interpretation, references to mental hospitals as IMDs are less meaningful in the context of services to the aged than if the references had been associated with the general exclusion.

We also conclude that the Agency interpretation does not conflict with the statutory provisions and legislative history related solely to ICFs and relied upon by the States. That Medicaid covers some persons placed in an ICF due to mental condition, where those persons might otherwise have been placed in a mental hospital, does not necessarily mean that it covers all such persons. Under the Agency interpretation, a person with a mental condition is covered in an ICF so long as the ICF is not an IMD and, even if the ICF is an IMD, the person may be covered if over age 65.[14]

Moreover, we are not persuaded that the Agency must adopt the description of the exclusion set forth in the court cases cited by the States. Those cases did not directly involve the issue presented here. *Schweiker,* in particular, involved an issue of payment of Supplemental Security Income benefits to inmates of *public* institutions who were not receiving Medicaid benefits. Thus, the Court was only concerned with the exclusion of patients in public IMDs and statements in the opinion must be taken in that context.[15]

---

[13] The States were given a limited time period in which to bring their institutions up to these standards, but in the meanwhile had to meet other standards, including standards related to safety, to staffing requirements, and to an active program of treatment. See, Handbook of Public Assistance Administration (HPA), Supplement D, Medical Assistance Programs, Section D-5141.14.d.(2) (1966); 34 Fed. Reg. 9784, June 24, 1969 (extending deadline for compliance to July 1, 1970).

[14] We also do not place any significance on the use of the term "public institution for mental diseases or defects" in Section 1905(c) of the Act with reference to ICFs. See footnote 4 above. That provision must be read in light of the exception for ICF services in public institutions for the mentally retarded in Section 1905(d), immediately following this language.

[15] We also note that the statement which provides the strongest support for the States' position is quoted from the dissent rather than the majority opinion in *Schweiker.*

As a matter of policy, the States present an appealing argument that classifying private SNFs and ICFs as IMDs may counteract Congressional incentives to move patients out of the large State mental institutions. The Agency has, however, based its interpretation on the policy judgment that if private, free-standing SNFs or ICFs could never be IMDs, the States might use these facilities as inappropriate substitutes for State institutions rather than as appropriate alternatives.

The Agency interpretation, while not the only possible one, is reasonable and is supported by the statute. Moreover, as we discuss in the following section of our decision, the Agency interpretation that SNFs and ICFs such as those involved here can be IMDs is embodied in duly promulgated regulations.[16]

III. The Regulations

The major issue concerning the Agency regulations is whether they were sufficient to give the States notice that the facilities involved should be classified as IMDs. The States contend that the regulations should be read in light of the legislative history of the exclusion to apply only to mental hospitals and are too vague as applied to the SNFs and ICFs here. As discussed below, we conclude that the regulations were clear enough to give the States notice that an SNF or ICF could be an IMD and, in the context of the specific facts here, the regulations were properly applied.

Our discussion of the regulations is divided into three parts: the history and wording of relevant provisions; a statement of the parties' arguments related to the regulations; and our analysis of the issues.

---

[16] We do not here adopt the Agency's unqualified statement, expressed at the hearing, that the exclusion is meant to continue the States' "traditional financial responsibility for the mentally ill." Tr., p. 21. The exclusion is directed at the States' responsibility for individuals in a certain type of institution. The regulations, in using the term "overall character," reflect this emphasis. The Agency does not deny that Medicaid funding is available for patients with mental diseases placed in a "general" SNF or ICF. Moreover, prohibitions on assistance to individuals with a diagnosis of psychosis who were in general medical institutions were deleted in 1965.

A. Relevant Regulatory Provisions

The Handbook of Public Assistance Administration, Supplement D, Medical Assistance Programs (HPA), published in 1966, restated the statutory provisions concerning IMDs and provided that FFP could not be claimed in medical assistance for—

> Any individual who has not attained 65 years of age and is a patient in an institution for ... mental diseases; i.e., an institution whose overall character is that of a facility established and maintained primarily for the care and treatment of individuals with ... mental diseases (whether or not it is licensed). HPA, D-4620.2.

HPA provisions were later incorporated into codified regulations. Regulatory provisions at 45 CFR § 249.10, added June 24, 1969, 34 Fed. Reg. 9784, dealt with the amount, duration, and scope of medical assistance. They contained a general limitation on FFP "with respect to ... any individual who has not attained 65 years of age and who is a patient in an institution for ... mental diseases." § 249.10(c). "Inpatient hospital services" in which FFP was available were defined, in part, as "for the care and treatment of inpatients ... in an institution maintained primarily for treatment and care of patients with disorders other then ... mental diseases ...." § 249.10(b)(1). Skilled nursing home services were defined, in part, as "furnished by a skilled nursing home maintained primarily for the care and treatment of inpatients with disorders other than ... mental diseases ...." § 249.10(b)(4)(i).

Section 248.60, added to 45 CFR at 36 Fed. Reg. 3872, February 27, 1971, contained the provisions with respect to "institutional status" and its effect on availability of FFP under Medicaid. The section basically paralleled HPA § D-4620.2 language on "overall character" of an IMD. 45 CFR § 248.60(a)(3)(ii). It also contained the following definitions:

> (1) "Institution" means an establishment which furnishes (in single or multiple facilities) food and shelter to four or more persons unrelated to the proprietor, and

> in addition, provides some treatment or services which meet some need beyond the basic provision of food and shelter.
>
> • • •
>
> (7) "Institution for mental diseases" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services. 45 CFR § 248.60(b).[17]

Current provisions are similar but reflect the addition of ICF services and of inpatient psychiatric facility services for individuals under age 21 and, also, the change to use of Medicare standards for skilled nursing services. The key definition of an IMD, at 42 CFR § 435.1009, incorporates several earlier provisions as follows:

> "Institution for mental diseases" means an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

B. The Parties' Arguments on the Regulations

Basically, the States' position is that they had a reasonable expectation of funding for these SNFs and ICFs here because they relied on the legislative history of the exclusion and past practice of the Agency in applying the regulation only to "mental hospitals." The States further argue that, even if the

[17] Sections 249.10 and 248.60 were redesignated, 42 Fed. Reg. 52827, September 30, 1977, and then recodified, 43 Fed. Reg. 45176, September 28, 1978.

regulations could apply to private, free-standing SNFs or ICFs under some circumstances, the regulations were improperly applied here. On the latter point, the States focus on key words in the regulation, arguing either that the terms are too vague or that they should be interpreted a particular way.

For their view that the regulations should be interpreted to refer only to institutions with an "overall character" like a traditional mental hospital, the States rely in part on the legislative history of the exclusion.

They point out that the references to IMDs as mental hospitals in relation to the 1965 Amendments were made only a year before the medical assistance provisions of the HPA were issued. CT Br., p. 5, n. 2. Further, the States argue, the use of the term "overall character" in the regulations is an indication that the emphasis would be on the nature and type of institution rather than on the patients. The States point to those institutions which the States recognize as IMDs, the character of which is "unambiguous and a matter of public knowledge." CA Reply Br., p. 5. Focusing on the nature and purpose of the facilities, the States argue, allows for accepting the published regulations as valid since "[o]nly traditional state mental hospitals or their functional equivalents are truly institutions established and maintained for the purpose of diagnosis, treatment and care of persons with mental diseases." CA Reply Br., p. 5.

The States argue that their interpretation of the exclusion was a long-standing one, and that they acted on the basis of this understanding without attempting in any way to disguise their programs. CA Reply Br., p. 16. On the other hand, they argue, the Agency interpretation is a new one. According to the States, there had been no effort by the Agency to apply the regulatory definition of an IMD to nursing homes until the issuance of a General Accounting Office report, followed by field staff instructions in 1975. IL Reply Br., p. 2. Thus, the States argue, applying the definition to the facilities here amounts to a retroactive interpretation of the regulations.

This "retroactive" interpretation should be disfavored, the States argue, because it leads to "a proposed wholesale recoupment of federal funds," devastating to the States' budgets. CA Reply Br., p. 17. Given this effect, the States contend, the

Board should apply the rationale set forth in the recent Supreme Court case of *Pennhurst State School and Hospital* v. *Halderman*, 101 S. Ct. 1531 (1980). That decision is relevant, the States argue, because it points up the need to consider the legitimate expectations of the States in grant programs. CA Reply Br., p. 16; CT Reply Br., p. 15.

The Agency does not allege that the regulatory definition had been applied to private, free-standing SNFs and ICFs prior to these disallowances, but argues, "The States' contention that HCFA has in some way changed its policy with regard to the definition of IMD is completely unfounded." Cons. Br., p. 38. In support of this, the Agency points to the HPA, which, it states, "makes clear that hospital, SNF, and ICF services are all defined as services provided in those institutions." Cons. Br., p. 38. In particular, the Agency cites to the definition of a skilled nursing home for Medicaid purposes as one maintained primarily for patients without mental disorders. Cons. Br., p. 38, citing HPA D-5141.14.b. From this, the Agency concludes that the States have clearly known since 1966 that the Agency interpreted IMDs to include nursing homes.

The Agency states that, under the regulatory definition of an institution, hospitals, SNFs, and ICFs can all be institutions. Since the regulation sets no categories of institutions but looks to "everall character," the Agency argues, the regulation "requires an individual institution-by-institution determination, not a blanket prohibition as the states propose." Cons. Br., p. 37.

The States further argue, however, that the terms "diagnosis" and "treatment" in the regulatory definition provide a basis for distinguishing the SNFs and ICFs here from recognized IMDs covered by the definition. According to the States, an IMD performs a diagnostic service "to determine if a person is mentally ill through competent medically accepted, psychiatric techniques of diagnosis," and this is distinguishable from what SNFs and ICFs do, which is "relying upon historical diagnoses or diagnoses from some other institutional setting." Tr., p. 86.

The States also argue that the term "treatment" in the regulation must mean more than the mere "services" which are

provided to anyone in an SNF or ICF. In the States' view, "treatment" as contemplated by the regulation means an attempt to cure, which "involves very active efforts in treating the underlying pathology." Tr., p. 87.[18]

The States recognize that SNFs and ICFs provide some services provided by mental hospitals, such as food, shelter, and management of daily problems. Yet, the States assert that this is not sufficient to characterize these facilities as IMDs because "there is no psychiatric component to any of those treatment modalities." Tr. p. 88.

The States challenge the Agency interpretation as so overbroad that under it any institution that provided some treatment or services to a person who is mentally ill would become an IMD. This is inconsistent, the States contend, with the Agency's own regulations which define "institution" broadly, but use IMD as a clearly limited subset of institutions. Tr., p. 85. See also, CA Reply Br., p. 6.

The Agency counters that an institution may be an IMD if engaged in providing diagnosis, treatment, *or* care, and therefore need not be performing diagnosis. In response to the States' interpretation of the term "treatment," the Agency points out that regulations at 42 CFR § 456.380 require that ICFs provide a plan of treatment. According to the Agency, the regulatory definition of an IMD "mandates that facilities be classified according to the overall character of the patient population, not according to the services provided." Agency response to appeal, Docket Nos. 79-52-MN-HC and 79-89-MN-HC.

Finally, the States point out that the term "mental diseases," not defined in the regulation, is vague. In applying the regulation, the Agency referred to a disease classification

[18] California distinguishes nursing home services from "clinical treatment" performed by recognized IMDs, associating the term "clinical" with treatment provided by psychiatrists and clinical psychologists. CA Reply Br., p. 3., n. 2. The Director of the Illinois Department of Mental Health referred to the distinguishing factor as "psychiatric intervention." Tr., pp. 287, 299.

system known as the ICDA.[19] The States contend that the Agency definition, using mental disorders under the ICDA, was overbroad since it included mental states resulting from an underlying physical disease. CA Supplemental Statement in Support of Application of Review (CA Supp. App.), pp. 44-45, see also, CT. Br., pp. 44-45. The States also allege that the Agency confused use of the terms "mental impairment," "mental disability," and "mental disease" and this led to inconsistent application of definitions.

The Agency responds that—

> Congress used the term "mental disease" in 1965 . . . to mean what were commonly known as mental disorders at that time. The [ICDA] is a reasonable guide to the universe of "mental diseases." Establishing a physical cause for "psychiatric symptoms" does not change the fact that "psychiatric symptoms are what Congress meant when it said "mental diseases." Agency response to appeal, Docket No. 80-184-CA-HC, p. 26.

C. Discussion of the Regulatory Issues

Although there is some basis for distinguishing the issue in the *Pennhurst* case from the issue presented here,[20] we agree with the States that the *Pennhurst* rationale is relevant. If the States are to plan their Medicaid programs, they must know on what basis a facility will be classified as an IMD, particularly if that classification can be avoided by choices on patient placement. In examining whether the regulations in question were sufficient to inform the States that they could not expect funding for services in these particular facilities, however, the issue of clarity must be examined in light of the specific facts presented here.

[19] "International Classification of Diseases, Adapted for Use in the United States," Eighth Revision, Public Health Services Publication Number 1693.

[20] In *Pennhurst*, the issue was whether a statutory statement of patients' rights imposed an affirmative duty on States to expend their own funds as a condition for receiving Federal funding. Here, we are dealing with the scope of an exclusion of funding, where the States' interest in clear notice must be weighed against the Federal government's interest in not funding services Congress has refused to cover.

The evidence discussed in section V below establishes that very high percentages of patients in these institutions had disorders which were identified as mental disorders under a generally accepted classification system, that the facilities in most instances held themselves out as caring for the mentally ill, that some of the services provided to the patients could reasonably be considered "treatment," and that the facilities had other characteristics supporting the conclusion that the regulations apply. Thus, we are not dealing here with close calls concerning the Agency's application of a questionable criterion; in virtually all cases, the facilities involved had attributes which placed them securely within any reasonable reading of the Agency's regulation.

The States' major argument is that the regulations must be viewed in light of the legislative history of the exclusion and the States' understanding of the exclusion. Since the States viewed the regulations this way, the States claim, they had an expectation of funding for these facilities and the disallowances result from an unfair retroactive interpretation of the regulation. Even if we were to concede that the States interpreted the regulations in light of a certain understanding of the exclusion, we would not necessarily be led to the conclusion that the States' interpretation was reasonable, given the plain language of the regulations.

The regulations state that an IMD is, first of all, an institution. The term "institution" is defined for these purposes as "an establishment that furnishes ... some treatment or services to four or more persons...." This is a longstanding interpretation which is inconsistent with the view that the exclusion applies only to large warehouselike facilities. We are not persuaded that this definition is not significant merely because IMDs are a specific subset of all institutions. There is nothing in the regulations to indicate that the scope of the IMD "subset" is related to institutional size.

Moreover, an institution may encompass a single facility or multiple facilities, and may be public or private. While the regulations do not specifically state that a single, private facility

is an IMD if otherwise meeting the definition, it is a logical implication from the definition taken in context.[21]

The States also argue that the regulations should be interpreted in light of the statement in *Schweiker* that mental hospitals were treating only the mentally ill. This view does not comport with the use of the term "primarily" in the regulations. It is a clear implication from the use of that term that an IMD may also be providing care and treatment to persons other than patients with mental diseases. Moreover, the early definition of inpatient hospital services as services in an institution primarily for persons with disorders other than mental diseases (with the parallel definition of skilled nursing services) indicates that the nature of the patient population is pertinent. While we agree with the States that the term "overall character" reinforces a view that the focus of the exclusion is on the nature of the institution itself, we fail to see how one can totally separate the nature of the institution from the patients it serves.

The States' attempt to distinguish the facilities here from recognized IMDs on the basis that these facilities do not perform diagnostic services and do not provide the same degree of treatment also fails in light of the plain language of the regulation. The term "diagnosis" appears before the disjunctive "or." The regulation cannot reasonably be read to infer that only institutions performing diagnosis are IMDs.[22]

With respect to the States' interpretation of the meaning of the term "treatment," we agree with the Agency that this interpretation is inconsistent with the States' own position that

---

[21] Congress apparently considered ICFs and SNFs to be institutions. The statutory definition of an ICF at Section 1905(c) refers to persons requiring care which could be made available only through "institutional facilities," and to "institutional services" deemed appropriate in certain sanatoriums. An SNF is defined at Section 1861(j) as "an institution (or a distinct part of an institution)...."

[22] While the States have presented some evidence that SNFs and ICFs do not perform a full range of diagnostic services, the record does not fully support a conclusion that the facilities here did not engage in some diagnostic functions. In fact, a statement by a psychiatrist from the California Department of Mental Health who testified at the hearing was to the effect that he would not expect an *emphasis* on diagnosis in a SNF. Tr., p. 204. This implies that he would expect some diagnosis to occur.

the regulation should be read in light of the legislative history and the circumstances at the time the exclusion was originally enacted. Congress has provided incentives to upgrade the quality of treatment in mental institutions and to ensure "active" psychiatric treatment for individuals for whom Federal funding would be available. See, Sections 1902(a)(20) and 1905(h)(1)(B)(i) of the Act. There is a substantial question, however, whether recognized IMDs were providing this kind of treatment at the time the exclusion was enacted. We also note that the regulation speaks of treatment *of* persons with mental diseases, not treatment *for* mental diseases.

Contrary to other statutory and regulatory provisions which specify a certain type of treatment, the regulatory definition of IMDs merely says "treatment." The States have pointed to nothing that supports a conclusion that the SNF and ICF services here did not constitute "treatment" within the meaning of the regulation.[23]

The term in the regulation which is most readily subject to various meanings is the term "mental diseases." Here, again, the States' arguments have internal contradictions. While the States accuse the Agency of using an overbroad definition in light of current knowledge of the causes of mental symptoms, the States have not shown that that definition was broader than those categories of persons treated in mental hospitals at the time the exclusion was enacted.

The States would have us overturn the Agency determinations since the Agency included patients with mental disorders where the States say the primary diagnoses were physically-based diseases, and since the Agency included patients whose diseases were probably misdiagnosed. The regulations, however, merely say "persons with mental diseases." Thus, to the extent that the Agency evaluated patients at all on the basis of

[23] The States' position that these nursing homes were providing a level of services which does not constitute treatment of patients also does not comport with numerous statutory and regulatory uses of the terms. For example, Section 1905(c) of the Act describes ICF services as those for persons who do not require the "degree of care and treatment" provided by an SNF. Also, the original definition of skilled nursing home services included reference to homes for "care and treatment" of patients. HPA D-5141.4.

primary rather than secondary diagnosis, this was a narrowing of the regulation from which the States benefited. Moreover, for the most part, even excluding patients with physically-based mental disorders, these facilities were serving primarily persons with mental diseases.

We agree with the States that the Agency sometimes may have confused the use of various terms related to mental status. In clarifying proper usage, however, California's expert states, "Impairment and disability are terms describing the effects of disease on functioning, while disease is a diagnostic concept." CA Supp. to App., Exhibit C, p. 53 (footnote omitted). Since the Agency findings are related to diagnosis, we conclude that Agency misuse of terms, while unfortunate, did not prejudice any State and is consistent with Congress' use of the term "mental diseases."

Moreover, we agree with the Agency that its use of the ICDA was reasonable. The States have not disputed that the ICDA is a generally recognized classification system. While the States' testimony establishes that the ICDA is subject to some difficulties in application, it also establishes that any attempt to classify illness presents such difficulties. To preclude the Agency from adopting any classification system at all would render the exclusion totally unenforceable.

Thus, we conclude that the regulations were sufficiently clear to inform the States that these facilities were IMDs and funding would not be available for services to patients in the facilities. Given that the regulations are sufficiently clear to apply to these facilities, to the extent that the States relied on the fact that the exclusion had not been applied to this type of facility before, that reliance is unreasonable. Moreover, the Agency should not be precluded from fully enforcing a regulation merely because it has never been applied a particular way in the past. The Agency must be able to respond to changing circumstances, by enforcing an existing regulation.

IV. The Criteria

Thus far, we have considered the States' arguments related to Congressional intent and to the regulations themselves. In

this section, we consider the States' arguments concerning the Agency criteria for applying the regulations, set out in instructions to field staff. We conclude that these arguments also do not provide a basis for overturning these disallowances.

Our discussion of the issues related to the criteria is divided into five parts: the history of development of the criteria; the parties' arguments on procedural issues related to the criteria; our analysis of the procedural issues; the parties' arguments on substantive issues related to the criteria; and our analysis of the substantive issues.

A. History and Statement of the Criteria

The Agency "criteria" for determining IMD status were set forth in a series of documents which were part of an Agency transmittal system called the Field Staff Information and Instruction Series (FSIIS). FSIIS FY-76-44, dated November 7, 1975, was addressed to the Regional Commissioners of the Social and Rehabilitation Service (SRS), then responsible for administering the Medicaid program, and informed them that regional office findings and a General Accounting Office study had indicated that FFP was being improperly claimed for Medicaid for individuals between 21 and 65 in IMDs. This document cites the regulatory definition of IMDs and states:

> The character rather than the licensure status of the institution is of paramount importance .... An institution is characterized as "primarily" one for mental diseases if it is licensed as such, if it advertises as such or if more than 50 percent of the patients are in fact patients with mental disease. In some instances a facility may be "primarily" concerned with such individuals because they concentrate on managing patients with behavior or functional disorders and are used largely as an alternative care facility for mental hospitals, even if less than 50 percent of the patients have actually been diagnosed as having a mental disease. Mental diseases are those listed under the heading of mental disorders in the [ICDA], except that mental retardation is not included for this purpose.

The document requested information from the regions on the problem of improper claiming for services in IMDs, stating

that the focus should be on SNFs and ICFs since "we assume, absent evidence to the contrary that improper claims related to age are not a problem for care in psychiatric hospitals."

FSIIS FY 76-97, issued May 3, 1976, stated that responses to the earlier instruction "have heightened our awareness of great discrepancy in the understanding, interpretation, and implementation of policy" with respect to IMDs. The document points to the regulations as a basis for the conclusion that free-standing SNFs and ICFs may of themselves be IMDs, expresses concern with improper claiming, and advises regions to "assess or continue to assess the situation as it now exists in order to assist the States where necessary in complying with applicable Federal Regulations."

A third document, FSIIS FY-76-156, dated September 14, 1976, addressed mental health under Title XIX in general and noted progress in the efforts to assure observation of the prohibition on funding in IMDs. This document referenced the earlier transmittals and stated:

> Various methods in addition to those discussed in earlier issuances have been suggested to help States identify suspect facilities, including proximity to State institutions (for example, within a 25-mile radius) and age distribution uncharacteristic of nursing home patients (i.e. a preponderance of individuals under age 65). Also, included in these methods would be a determination as to whether the basis of Medicaid eligibility of patients under 65 in suspect facilities was due to mental disability.

FSIIS FY-76-156 recommended use of review teams "to review patients in those facilities where the determination [of IMD status] cannot be made without applying the 50% criterion." It also set out a system for classifying patients, according to physical problems and mental disability, to determine whether the person's need for skilled nursing or intermediate care resulted from a mental disability.

In a memorandum to the Regional Attorney, Region IX, HEW, dated September 16, 1977, the regional office requested

a legal opinion on the criteria set out in the FSIIS series, summarizing the criteria as follows:

1. Licensed as mental institutions.
2. Advertises as mental institutions.
3. More than 50 percent of the patients have a disability in mental functioning.
4. Used by mental hospitals for alternative care.
5. Patients who may have entered mental hospital accepted direct from community.
6. Proximity to State mental institutions (a 25 mile radius).
7. Age distribution uncharacteristic of nursing home patients.
8. Basis of Medicaid eligibility for patients under 65 due to mental disability.

Attachment IV to Appendix D to CA Audit Report.

The October 28, 1977 response, prepared by an Assistant Regional Attorney, expressed the opinion that the criteria were interpretative rules which "constitute both clarification and more specific explanation of existing law and regulations." Appendix E to CA Audit Report. The Assistant Regional Attorney's memorandum, included with all but one of the Agency audit or review reports used here, further states:

> Obviously some of the above listed criteria are more probative as to whether a facility, given its "overall character", is "primarily" engaged in IMD type activity, e.g. the fact that a facility is used by mental hospitals for alternative care (#4) is more probative than the fact that a facility happens to be located within a 25 mile radius of a state mental institution . . . . p. 8.

The memorandum warns that "every indication of any significance that a given facility is primarily engaged in IMD activity should be marshalled to fulfill the regulatory mandate

that the determination be on the basis of the facility's 'overall character' . . . ." pp. 8-9.

The auditors and reviewers making the determinations disputed here all used four or more of the criteria. Two additional factors, considered by the reviewers in Connecticut were—

9. Hires staff specialized in the care of the mentally ill.
10. Independent professional reviews conducted by state teams report a preponderance of mental illness in patients in facility. CT Review Report.

With respect to the criteria, the States raise a number of procedural arguments. They also attack the criteria substantively, particularly challenging the so-called "51% rule" (Criterion #3) as inconsistent with the statute and regulations and with prohibitions on discrimination on the basis of diagnosis. The States allege that the criteria were inconsistently applied by the Agency and present serious administrative difficulties.

B. The Parties' Arguments on Procedural Issues

The States first argue that they did not have timely notice of the criteria and therefore cannot be adversely affected by the criteria since the criteria were not published in the Federal Register. In support, the States cite 3 U.S.C. § 552(a)(1).

Whether the criteria are substantive rules or interpretative rules, the States contend, they should have been published because they have "general applicability." This "general applicability" is shown, in the States' view, by the "fact that HCFA issued the criteria to all SRS regional commissioners and has used them as a basis for disallowances against four states . . . ." CT Br., p. 33. The States cite the case of *Appalachian Power Co.* v. *Train,* 566 F.2d 451, 455 (4th Cir. 1977), for the proposition that information is required to be published under § 552(a)(1) if it is "of such a nature that knowledge of it is needed to keep outside interests informed of the agency's requirements in respect to any subject within its competence."

The States also argue that, under the Department's own regulations,[24] the criteria should have been published in accordance with the notice and comment rulemaking procedures of Section 4 of the Administrative Procedure Act (APA), 5 U.S.C. § 553. Since this section applies only to substantive rules, the States allege that the criteria were more than an interpretation clarifying or explaining existing law, and, in this connection, point out that the label assigned to a rule by an administrative agency is not determinative. CT Br., p. 35, citing *Anderson* v. *Butz*, 550 F. 2d 459, 463 (9th Cir. 1977); *Continental Oil Co.* v. *Burns*, 317 F. Supp. 194, 197 (D. Del. 1970).

Further reason why the criteria should have been published, the States argue, is that the criteria had a "substantial impact" on the States. Using the test for "substantial impact" set forth in *Continental Oil Co., supra*, 317 F. Supp. at 197, the States present an analysis to show that the criteria are complex and pervasive; represent significant changes from existing law; have retroactive effect; and have engendered confusion and controversy. CT Br., pp. 36-37; see also, IL Application for Review, pp. 10-11; Tr., pp. 74-76. Based on this analysis, the States conclude that the Agency's failure to use notice and comment rulemaking to promulgate the criteria renders them invalid.

Finally, the States attack the criteria as procedurally defective on the grounds that use of the criteria without giving notice to the States of the criteria themselves, of the Agency's intent to use them as an enforcement tool, and of the meaning of the criteria violates principles of due process and fundamental fairness.

The Agency does not dispute that the States may not have had notice of all the criteria, Tr., pp. 18-19, but explains its position as follows:

> The criteria . . . discussed in the FSIIS's were never intended to be criteria as such. They were merely

[24] On February 5, 1971, the Department of Health Education, and Welfare (HEW, now HHS) adopted notice and comment rulemaking for matters relating to "public property, loans, grants, benefits or contracts," otherwise exempted under the APA. 36 Fed. Reg. 2536.

> guidelines. . . . they merely discuss the central office's view of what factors might be helpful in locating, identifying, possible IMD's and evaluating possible IMD's. They were never intended to be the kind of criteria that you would assign a numerical score to, and none of the criteria was ever considered determinative with respect to the nature of the facility. Tr., pp. 15-16.

In support of this, the Agency points to inclusion, with the reports, of the Regional Attorney's legal opinion on applying the criteria in relationship to the regulation. Tr., p. 16.

According to the Agency, the criteria are interpretative rules, constituting clarification of existing policy embodied in the duly promulgated regulations; they were not required to be published because they were not "for the guidance of the public."[25]

The Agency further argues that the FSIIS "include obvious factors for determining which institutions might be primarily engaged in the treatment of persons with mental diseases. Cons. Br., p. 44. There is nothing confusing, drastic, or retroactive about the criteria, the Agency states, since they merely aid in the implementation of HCFA policy that has been clear and consistent since 1966." Cons. Br., p. 44. See also, Tr. p. 16.

C. Discussion of Procedural Issues

In view of our conclusion above that the regulation itself was sufficiently clear to give the States notice that these

[25] In support of this, the Agency cites the *Attorney General's Manual on the Administrative Procedure Act* (1947) at 22 for the statement that "interpretations need be published only if they are formulated and adopted by the agency for the guidance of the public. The Act leaves each agency free to determine for itself the desirability of formulating policy statements for the guidance of the public." Cons. Br., p. 42; see also, Tr., p. 18. We note that the version of 5 U.S.C. § 552(a)(1) quoted by the Agency appears to be an earlier version, prior to the 1967 amendments, Pub. L. 90-23. The Agency version contains the phrase "for the guidance of the public" as a description of covered interpretations, whereas the current version places the phrase in the introductory language, requiring publication "for the guidance of the public." In view of our conclusion below, we do not address the significance of this difference.

particular facilities were IMDs, we conclude that the Agency's failure to publish or otherwise give the States notice of the criteria would not provide a basis for overturning these disallowances. The adverse effect, and financial impact, of these disallowances is a result of the regulations rather than the criteria since these facilites had the requisite "overall character" under any reasonable reading of the regulation. Thus, we cannot say that the Agency's actions prejudiced the States, given the circumstances presented here.

The FSIIS series documents show that the Agency viewed the criteria as indicators of whether a facility was an IMD under the applicable regulations. The Agency used some or all of the criteria in making each of the disallowance determinations here, but none of the criteria was considered determinative. The cumulative evidence is that the facilities met the regulatory definition.

We also note that many of the States' arguments with respect to the need for notice or publication are premised on the view that the criteria amounted to a change in existing law, since their understanding was that only mental hospitals were IMDs. As stated above, the regulations in context clearly imply that private, free-standing SNFs and ICFs can be IMDs. Moreover, while it is unclear from the record at what point the States had actual notice of the criteria themselves, it appears likely from the record that the States were aware prior to the periods of disallowance that the Agency interpreted the regulation as applying to such SNFs and ICFs.[26]

---

[26] The FSIIS series documents indicate that the regional offices were to involve the States in addressing the problem of whether SNFs and ICFs were IMDs. There is also other evidence that some of the States knew of this application of the regulation. See, e.g., Letter of October 4, 1971 from Associate Regional Commissioner, SRS, to Director CA Department of Health Care Services (relating the IMD exclusion to services provided "by nursing homes or in hospitals"), Agency Admin. Record, Tab 1; Tr., p. 129 (Testimony of Connecticut Public Assistance Consultant that "around 1976" her Department was aware of the position that ICFs and SNFs could be IMDs); Letter of December 29, 1977, from Assistant Commissioner, Minnesota Department of Public Welfare, Attachment 6 to MN Audit Report.

D. Substantive Issues Related to the Criteria

The States also attack the criteria substantively, focusing primarily on the Agency's counting of patients with mental disorders (Criterion #3), but also making some general arguments. The parties' substantive arguments are summarized below, followed by our analysis.

1. Substantive Arguments Related to the Counting of Patients

The States direct their substantive attack on the criteria mainly against Criterion #3, referred to as the "51% Rule," arguing that it is arbitrary, invidious, and contrary to prohibitions against discrimination on the basis of diagnosis. For support of their proposition that the counting of patients is discriminatory, the States cite Social Security Act provisions which forbid a State from discriminating against any eligible individual with respect to the amount, duration, and scope of medical assistance, Section 1903(a)(10), and regulations which prohibit a State from denying a required service to an otherwise eligible individual solely because of diagnosis, type of illness, or condition. 42 CFR § 440.230. The States also cite a policy guide and other Department issuances which reflect a policy of nondiscrimination on the basis of diagnosis. CT Br., pp. 25-26. Moreover, the States argue, the Agency approach "encourages segregation of individuals with mental diagnosis in certain facilities on the basis of considerations other than their individual needs," and thus violates Section 504 of the Rehabilitation Act of 1973, as amended. CT. Br., p. 28.

In response, the Agency asserts,

> The statute provides, quite simply, that no FFP is available for services provided in an institution for mental diseases. . . . once a facility is determined to be an IMD, no federal financial participation is available for services to any resident of the facility, whether or not a resident is mentally ill. . . . To paraphrase the Supreme Court's holding in *Schweiker* v. *Wilson*, . . . the distinction is not between the mentally ill and a group composed of the nonmentally ill, but rather between residents of IMDs and

residents of other long-term care facilities. Cons. Br., p. 53.

Other problems which the States raise with respect to Criterion #3 include the arbitrariness of diagnostic labeling of patients, the difficulties of categorizing patients with multiple disorders, the problems inherent in using the ICDA, the unreliability of medical records, and the administrative headaches potentially caused by changes in patient population. The States presented testimony that the fact that a patient once carried a label of being mentally ill had nothing to do with the current status of the patient, and, since the auditors did not engage in a procedure to determine whether a patient still had an acute, active illness, use of a previously-given diagnosis amounted to "gross prejudice." Tr., p.279; see also, Tr., p.298. According to the States, diagnosis is a judgmental process, which may depend in part on the particular specialty of the doctor engaged in the process. Determining reasons for placement in a particular facility is particularly complex with respect to patients with multiple diagnoses, the States point out, with supporting testimony. Tr., pp. 187-188.

The States attack the use of the ICDA as a basis for categorizing patients by presenting testimony that SNFs and ICFs have no legal restrictions in terms of using the ICDA and concluding from this that an Agency reviewer might be confronted with diagnoses which do not fit the ICDA categories. Tr. pp. 182-183. The States also argue that a "51% Rule" is completely unworkable because patient population can shift and, under the rule, admission of one additional patient with a mental disorder could result in loss of Medicaid coverage for all patients in a facility.

The Agency in rebuttal presented testimony by a psychiatrist who was on the review team which examined the Connecticut facility involved here. He stated that he carefully weighed judgment as to why a patient with multiple diagnoses was placed in the Connecticut facility. He further expressed the opinion:

> I don't think non-medical or non-nursing auditors would be able to have necessarily the same kind of

> credibility that I was able to have concerning the medical records. But if you assume that they are accurate and of reasonable quality, they do give you, I think, an accurate understanding of what is being treated. Tr., p. 331.

The Agency also defends use of the ICDA as a reasonable guide to the universe of "mental diseases," given that "complete agreement cannot be revealed with regard to systems of diagnosis . . . ." Cons. Br., p. 46. The Agency points out that trained medical staff conducted or aided in the review of patient records and claim forms here in order to establish diagnosis. The Agency states that its evidence shows that "the review terms were if anything very cautious and conservative in their applications of the categories." Cons. Br., p. 47, citing Tr., pp. 312-407.

In general, the Agency argues:

> As stressed in the controlling regulation, it is the overall character of the facility, and not merely the percentage of residents with diagnoses of mental illness, that is determinative. Moreover, the FSIISs specifically recognized the problems inherent in the arbitrary application of a percentage standard, under which a facility's status could change day-to-day. It made clear that the character of the facility would be determined once, and that status would continue until a special request to change it was filed: . . . FSSIIS (sic) FY-76-156 at 3. Thus, the admission of one patient with mental illness would not affect the character of a facility. Cons. Br., p. 52.

2. General Substantive Issues Related to the Criteria

The States attack all the criteria on substantive grounds as impermissibly vague and the Agency's use of the criteria as arbitrary and capricious. In general, the States argue that the criteria "are ill-defined, and they appear to be wholly inadequate indicators of whether an institution meets the 'primarily engaged' or 'overall character' standards of the published regulations." CT Br., p. 42; see also, Tr., pp. 100-101. With respect to specific criteria, the States challenge each of them as

"meaningless," "incomprehensible," "misleading," or otherwise irrelevant to the question of whether a facility is an IMD.[27]

The States also allege that the criteria were inconsistently applied. The States attribute this, in part, to what they say is a lack of objectivity to the criteria. Applying the criteria presents serious administrative difficulties, the States allege, because this method of identifying IMDs "involves a number of highly judgmental elements (e.g., what is 'mental disease,' how to deal with multiple diagnoses, how to categorize 'senility') which make it impossible for auditors to classify the facility, which make any classificiation likely to be both subjective and time-consuming, and which will inevitably lead to legitimate heated disagreements with the findings." CA Reply Br., p. 13; see also, CT Reply Br., pp. 8, 16.

In response, the Agency states:

> The "criteria", while varying widely in relative importance, are all useful in identifying possible IMBs. As indicated in the review reports that support the disallowances, none of them was ever deemed sufficient in itself to classify an institution. Cons. Br., p. 45-46.

The Agency argues that, in criticizing the Agency criteria but failing to suggest reasonable alternatives, the States appear to be saying that it is impossible to define an IMD and this would render the exclusion unenforceable. Tr., p. 20.

3. Discussion of the Counting of Patients

We agree with the States that there are difficulties with counting patients according to diagnoses based on medical records and with use of the ICDA. We also agree that it is not conclusive that a person is mentally ill merely because at one

[27] See, e.g., CA Application for Review, p. 9; CT Br., p. 42; Tr., p. 93 (Criterion #1); CA Application for Review, p. 9; CT Br., p. 43; Tr. p. 94 (Criterion #2); CA Application for Review, p. 10; CT Br., p. 47 (Criterion #4); CA Application for Review, p. 10; CT Br., p. 48 (Criterion #5); CA Application for Review, p. 10; CT Br., p. 49; Tr., p. 98 (Criterion #6); CA Application for Review, p. 10; CT Br., p. 49 (Criterion #7); CA Application for Review, p. 10; CT Br., p. 50 (Criterion #8).

time the person was diagnosed as mentally ill. With a few exceptions discussed in Section V below, however, the States' arguments on these points are generalized and speculative. The States have presented no evidence that, in any of these cases, the determination that the facility was an IMD was based solely on a finding that 51% of the patients had mental diseases.

As stated above, the Agency was reasonable in looking to patient population as a factor in determining "overall character" of a facility. Moreover, given the very difficulties in diagnosis and classification which the States point to, some choice had to be made of how to determine whether a resident was a person with a mental disease. The Agency did include some patients whose psychiatric symptoms might have been physically-based. On the whole, however, the Agency took a conservative approach, employing a current, generally recognized classificiation system. This approach benefited the States when viewed in light of the common understanding of the term "mental diseases" at the time the exclusion was enacted.

The Agency witness was persuasive on the general reliability of medical records and the ability of auditors to interpret them with relative accuracy. For the Agency to take some risk of misclassification was reasonable, where the patient population was not the sole basis for determining "overall character." While the ideal might be to engage in a lengthy diagnostic analysis to determine reasons for patient placement, it is simply administratively infeasible. We agree with the Agency witness, Tr., p. 331, that the degree of credibility in the medical record needed to understand what is going on is less than what would be demanded if someone were using it as a basis for treatment. Moreover, the States' arguments with respect to unreliability of records and possible misdiagnosis of patients ignore the consideration that, not only the Agency, but the facilities and the States were likely also dependent on historical diagnoses for their decisions on the appropriateness of placement. Even though a diagnosis of mental disease might be wrong, if it was a basis for placement of the patient in a facility, it is an indication of the nature of the facility as one engaged in care and treatment of mental diseases.

As stated above, we also think that the States benefited from the Agency excluding patients who were placed in the facility due to a physical problem even though they may have also been mentally ill. The regulation covers facilities for care and treatment of "persons with mental diseases," and this is not limited to persons with a primary diagnosis of mental disease.

We share the States' concern with administrative difficulties which might be caused by a shift from 49% to 51% population of mentally ill in a facility. This concern is irrelevant here, however, given the high percentages of mentally ill in most of the facilities during the disallowance periods and since other significant factors also evidenced "overall character" of the facilities as IMDs.

We also do not find the counting of patients here to be discriminatory. As the Court in *Schweiker, supra,* found, the exclusion is directed at a type of institution, not at the patients. The resulting disallowances flow from classification of a facility as an IMD, not from the counting of patients per se. This classification may have unfortunate results on placement decisions made by the States, and lead to mentally ill patients being segregated in IMDs or placed in facilities farther from their homes so that the exclusion could be avoided. However, any discrimination in this situation would be a result of the exclusion and the State seeking to maximize funding, and only tangentially the result of the Agency's counting of patients.

We also note that Medicaid provisions forbid denial of "medical assistance" on the basis of diagnosis. The Agency is using diagnosis here as a basis for determining whether services are, indeed, "medical assistance" or are excluded from being "medical assistance" because they are provided in an IMD.

Our holding here does not imply that the Agency could never apply a "51% Rule" arbitrarily. Given the facts of these cases, however, the criterion itself does not provide a basis for reversal of the disallowances.

4. Discussion of General Substantive Issues Related to the Criteria

With respect to the remaining criteria, we also find that they were applied here in a reasonable manner. If the Agency had relied solely on any one of them, we might view the issue differently. The Agency itself recognized, however, that some of the criteria were more probative than others and here used the criteria as a guide for accumulating evidence that the regulatory definition was met.

While all of the criteria might not be as obvious as the Agency alleges, neither are they as obscure as the States allege. In these particular cases, the findings which result from the Agency's use of the criteria do support the general conclusion that the facilities were IMDs, or, at least, do not detract from that conclusion.

There was some inconsistency in application of the criteria to the different States' facilities. For the most part, this merely reflected the differences in the States' programs and did not prejudice any State since the inconsistency in no case led to a legally incorrect application of the regulation. Further, the inconsistency in some instances favored the States since the Agency may have applied the criteria more conservatively than the regulations required.

Thus, given our conclusion that the regulations apply as a basis for the disallowances here, we further conclude that the Agency's failure to promulgate the criteria does not render these disallowances defective, and that, substantively, use of the criteria as tools for the application of the regulations was not arbitrary or discriminatory. We also conclude that while the criteria in some instances may have been inconsistently applied, these instances were not prejudicial and do not invalidate the Agency's findings as a whole. As discussed below, the Agency has presented persuasive evidence that each of these facilities met the regulatory definition of an IMD.

V. Analysis of Factual Issues

In this section, we discuss the facts related to the disallowances for each of the four States involved here, analyzing

the issues each State raised with respect to its particular case. The order of discussion (Connecticut, Illinois, Minnesota, and California) is the order in which the States presented their arguments at the joint hearing. Each subsection is organized differently, depending on the types of issues the particular State raised.

A. Connecticut

Docket No. 80-150-CT-HC involves a disallowance of FFP claimed by the State of Connecticut for services provided by Middletown Haven Rest Home (Middletown Haven), during the period January 1, 1977 through September 30, 1979. The disallowance was based on a report submitted by an Agency regional office review team,[28] which found that Middletown Haven was an IMD.

For reasons discussed below, we conclude that Middletown Haven was an IMD and uphold the Agency's disallowance.

1. The Reviewers' Findings in Connecticut

Both the Review Report itself and testimony at the hearing by the psychiatrist member of the review team show that the determination that Connecticut's Middletown Haven ICF met the regulatory definition of an IMD was based on careful consideration of a number of different factors. The reviewers specifically recognized that the criteria were factors to be cumulatively weighed, that they were not intended to be all-inclusive, and that they did not carry equal weight. CT Review Report, pp. 5-6.

The reviewers found that, during the disallowance period, Middletown Haven was certified as an ICF under the Medicaid program, but also had a license from the State with an "authorization to care for persons with certain psychiatric

[28] "Review of Costs Claimed by the Connecticut Department of Income Maintenance for Services Provided to Title XIX Recipients Residing at Middletown Haven Rest Home, Middletown, Connecticut, for the period January 1, 1977 through September 30, 1979," FM Control No. 3-8001, May 1980 (CT Review Report), submitted with agency response to the appeal.

conditions" ("psychiatric rider"). CT Review Report, p. 6, and Attachment D. The reviewers reported:

> The staff of the facility stated that not only is it identified in the license but that they view the facility as a psychiatric facility. Statements were made with regard to the patient population that it consisted mostly of mentally ill patients, for the most part transferred from . . . a State mental institution. Also, the statement was made that local hospitals have been advised of this specialty and will specifically refer patients with mental impairments . . . . Other indications were given during the interview that supported the team's conviction that the facility administration regards its license seriously and viewed itself as a licensed facility for psychiatric conditions. CT Review Report, p. 6.

The other indications the reviewers relied on included that the facility advertised itself to sources of referral as a facility specializing in the care of persons with mental diseases. This finding was based primarily on statements by the facility's administrator, but was partially verified through other means. CT Review Report, p. 7.

The reviewers also found that Middletown Haven hired medical and other staff which specialized in care of the mentally ill. The facility had a contract with three psychiatrists, requiring each of them to be an active staff member, to come in a least weekly for consultation on patients, and to participate in in-service education programs for the staff. CT Review Report, p. 12.

The factor which the reviewers thought indicated most clearly that Middletown Haven was "primarily engaged" in treating the mentally ill was the determination that, of the 469 patients deemed to have been patients in the facility from January 1977 to December 18, 1979, 364 or 77% had a major mental illness which was a substantial part of their need for ongoing ICF care.[29] CT Review Report, pp. 7-8 and Attachment F, p. 3.

[29] The 77% here included patients with diagnoses of alcoholism or organic brain syndrome where the record indicated that "the psychiatric

(footnote continues)

This determination was based on a very careful review of the available data, under the guidance of the psychiatrist on the team, who performed an in-depth analysis of a test sample and a detailed review of all cases where other team members had a question about how to classify a patient. CT Review Report, p. 8. This psychiatrist testified at length at the hearing on the rationale he applied to patients with multiple diagnoses. See, Tr., pp. 312-328.

Additional review findings included [sic] that a large proportion of Middletown Haven patients came from State mental institutions, that the facility is within three miles of a State mental institution, and that approximately two-thirds of the patients were between the ages of 21 and 65, which is uncharacteristic of nursing home patients in general. CT Review Report, pp. 8-11. The reviewers also cited an Independent Professional Review report, prepared by State teams, which commented on the "high incidence of psychiatric patients" in the facility. CT Review Report, p. 13.

2. Analysis of the Issues in Connecticut

Connecticut does not dispute the correctness of the reviewers' findings with respect to the facility's specialization and staffing, but does question their relevance. Connecticut contends that the specialization at Middletown Haven can be explained because it makes economic sense to have some concentration of individuals with a particular condition, so that some specialized services can be developed. CT Reply Br., p. 23. Given some concentration of patients with mental problems, it was logical, Connecticut argues, for the facility to seek staff with some relevant experience. Indeed, Connecticut

---

(footnote continued)

causes, complications or sequelae of these disorders were a significant part of the patients' ongoing need for ICF placement." CT Review Report, Attachment F, p. 2. The psychiatrist from the review team stated that the conclusion that a majority of the patients in the facility were mentally ill would still be valid, even excluding these categories. He further explained that the reason for including them was "their appearance as major mental disorders in ICD-8, DSM II, and all major textbooks of psychiatry, and the fact that the State of Connecticut treats this class of mentally ill in its state mental hospitals . . . ." Attachment F, p. 2.

asserts, federal regulations require a facility to have a staff that meets the needs of its residents. CT Br., p. 51. Connecticut also points out that the Medical Director of Middletown Haven was a general practitioner, not a psychiatrist, CT Reply Br., p. 20, and that many long-term care facilities have some staff with experience in caring for mentally disturbed residents. CT Br., p. 51.

The evidence shows, however, that the degree of specialization which occurred at Middletown Haven was significant. The staff viewed Middletown Haven as a psychiatric facility, primarily caring for the mentally ill. Whatever the facility's motivation for concentrating on the mentally ill, we find that the resulting situation strongly indicated that the facility had the "overall character" of an IMD. We also do not think, based on the record, that Middletown Haven was a typical general ICF in the services it offered. The Agency presented convincing testimony by the review team psychiatrist that the level of psychiatric treatment offered by Middletown Haven to its residents was greater than one would normally expect in ICFs. Tr., p. 328.

Connecticut did attempt to factually rebut some of the reviewers' other findings, primarily through the testimony of a Public Assistance Consultant for the Connecticut Department of Income Maintenance. This consultant testified that a "psychiatric rider" to a Connecticut nursing home license merely means that the facility cares for at least one mentally ill patient and has one staff person with psychiatric training. The witness further testified as to the differences between Middletown Haven and State mental hospitals, including that a State hospital provides a greater intensity of treatment and cares for patients with "acute mental disorders." Tr., pp. 138-140. Middletown Haven's admission policy did not permit it to care for persons with acute mental disorders. CT Review Report, Attachment E, pp. 1, 3.

The Connecticut witness also discussed the results of a review she had performed, based on reports by Independent Professional Review (IPR) teams in accordance with federal utilization control requirements. The witness testified that she

would not have concluded from her examination of these reports that in December 1979 a majority of Middletown Haven's patient population were persons with mental diseases. Tr., pp. 143-149; see also, Affidavit, Exhibit D to CT Br. She also gave examples of patients, with multiple diagnoses, whom she thought may have been misclassified by the reviewers as mentally diseased.

While we accept Connecticut's evidence as to the meaning of the "psychiatric rider" on Middletown Haven's license, and certainly would not view the presence of such a rider as determinative of the character of a facility, the fact that Middletown Haven had such a rider has some weight when viewed in the context of the other evidence here. We also are persuaded that there were distinctions between Middletown Haven and State mental hospitals during the disallowance period. Given the regulatory definition of an IMD, however, the fact that Middletown Haven was unlike a mental hospital in some respects is irrelevant to the issue of whether it was an IMD.

On the whole, we find the Agency evidence more persuasive with respect to the reasons for patient placement in Middletown Haven. The testimony of Connecticut's witness on possible misclassification was based on speculation from her review of the IPR reports, not on first-hand knowledge of what the reviewers did.

Moreover, we find that, as between the two witnesses, the Agency witness had more credibility. The Agency witness was highly qualified in psychiatry, Tr. pp. 309-310, whereas Connecticut's witness was not, Tr. pp. 144-145. Even if we agreed with Connecticut that some mistakes may have been made with respect to classification of individual patients, however, there would still remain overwhelming evidence that the "overall character" of Middletown Haven was that of a facility established and maintained for the care and treatment of persons with mental diseases.

Accordingly, we uphold the disallowance of $1,634,655 claimed by the State of Connecticut for payments to Middletown Haven for quarters ending March 31, 1977 through September 30, 1979.

B. Illinois

Docket No. 80-44-IL-HC involves a disallowance of FFP claimed by the State of Illinois for services provided to persons under 65 years of age in nine ICFs and SNFs during quarters ending December 1, 1976 through September 30, 1978. The Agency concluded that the nine facilities were IMDs based on a comprehensive review of eleven Illinois long-term care facilities. The review was conducted by two Medicaid Program Specialists from the Regional Medicaid staff.[30]

1. The Reviewers' Findings in Illinois

The reviewers examined medical review or independent professional review documents as well as utilization review data prepared by the Illinois Department of Public Aid and Public Health. These documents were prepared by registered nurses employed by the State and contained the diagnoses and treatment for each Medicaid patient, as recorded in the patient's actual medical records. Diagnoses in the ICDA were used to classify persons with mental diseases. The reviewers also examined advertisements, residents' handbooks, newspaper articles and internal State memoranda concerning the facilities.

The number of Medicaid patients with mental diseases in each of the facilities was found to represent at least 60% of the Medicaid population.[31] In all but two facilities, the number exceeded 85%. Statements in reports prepared by the Illinois Department of Public Health and Public Aid comfirmed for six of the facilities that resident population was made up primarily of mental patients or that the type of care was oriented towards mental patients. In the remaining three, the reviewers pointed to statistics concerning the use of each facility as alternative

---

[30] See "Report on Review of Institutions for Mental Diseases under the Medicaid Program," March 5, 1979 (IF Review Report).

[31] The Illinois, Minnesota, and California reviews examined only records of Medicaid patients, and, therefore, the percentages found were percentages of the total Medicaid population, not the total patient population, for each facility. The States have presented nothing, however, which would lead us to conclude that the Medicaid population was not representative of the total population. The assumption that it was appears to be reasonable.

placement for mental hospitals or the number of former mental hospital patients in the facility. The reviewers noted that in five of the facilities, the average age of the patient population was uncharacteristically low for nursing homes, e.g., 46 years. IL Review Report.

2. Discussion of the Issues in Illinois

Illinois expended most of its effort in this case arguing general legal issues. To the extent the presentation related peculiarly to Illinois, it related primarily to State policy and to the characteristics of all illinois ICFs rather than to the specific facilities found to be IMDs.

Illinois attacked the Agency criteria in general and the use of patient diagonsis in particular, presenting testimony on the dangers of patient labeling. Illinois also submitted evidence designed to show that its facilities certified as ICFs are distinguishable from State psychiatric hospitals. We have addressed these issues above.

With respect to the specific findings in Illinois, the State presented evidence primarily on three points: the legal requirements governing admission and discharge policies of Illinois ICFs; the nature of follow-up responsibility by the Illinois Department of Mental Health for patients in the facilities; and the significance of placement of patients from State mental facilities into these ICFs. We do not find that any of this evidence overcomes the Agency's findings as to the overall character of the specific facilities as IMDs.

Illinois has established that State regulations governing admission and discharge policies of ICFs expressly prohibit the admission or retention of persons who require "mental treatment" as defined in the Illinois Mental Health Code. That definition, however, refers to a person needing "mental treatment" if "that person is afflicted with a mental illness and as a result of such mental illness is reasonably expected ... to intentionally or unintentionally physically injure himself or other persons, or is unable to care for himself so as to guard himself from physical injury or to provide for his own physical

needs." IL Hearing Exhibit 5. Thus, need for "mental treatment" can certainly not be equated in Illinois with being mentally ill. In addition, the policies of the Illinois State Psychiatric Institute, a recognized IMD, indicate that a person might be discharged from a psychiatric hospital providing "mental treatment" into a long-term care facility "because of continuing illness, which has proved refractory to all available therapies which the hospital has to offer." IL Hearing Exhibit 2, p. 6.

Moreover, the admission policy of Grasmere Residential Home, Inc., one of the ICFs involved here, indicates that, while the Home did not provide "mental treatment," it did consider itself as providing some form of treatment to patients where therapeutically indicated. IL Hearing Exhibit 3.

Illinois also presented testimony regarding the scope of the jurisdiction of the Illinois Department of Mental Health and Developmental Disabilities. According to the Director of the Department, who testified at the hearing, the Department has jurisdiction only over the mentally ill in hospitals. Follow-up responsibility for persons placed from hospitals into facilities such as these ICFs does not include monitoring of individual patients, only evaluation of the patients' status as affected by the facilities programs. Tr., p. 301. The Department merely acts as an advocate for persons discharged from State mental health facilities. Tr., p. 284. Based on this, the State argued that the Agency should not have placed any significance on the fact that the Department had follow-up responsibility for a number of the patients placed in the ICFs here. IL Reply Br.

Illinois' evidence on this point is convincing to show the scope of the Department of Mental Health's jurisdiction and the nature of its follow-up responsibility. We would also agree that the fact of follow-up responsibility does not necessarily indicate continuing mental illness. However, Illinois has not demonstrated that patients for whom the Department had that responsibility were considered cured and were placed into these ICFs for purely physical illnesses. Indeed, the Agency's evidence shows that most of the patients were ambulatory and few had physical problems. Thus, while we do not consider the fact that the Department had follow-up responsibility for a

number of the patients placed in the facilities here to have great weight, we nonetheless consider it some support for the general finding that high percentages of the patients were mentally ill.

The remainder of Illinois' evidence is intended primarily to show that the placement of patients from State mental facilities into these ICFs does not mean these facilities were used as alternatives to the State facilities. In addition to pointing to Illinois regulations on persons requiring "mental treatment," discussed above, Illinois presents evidence to show: 1) persons placed in ICFs are placed there solely because they need the care that an ICF normally provides, Tr., p. 283-287; 2) only a small percentage of persons discharged from State facilities were placed in long-term care facilities during the disallowance period, IL Hearing Exhibit 6; and 3) the Department of Mental Health has placed persons in approximately 400 different facilities during the disallowance period, Tr., p. 291.

The Agency has not rebutted these points, and Illinois' evidence does indicate, at least, that the State was not arbitrarily "dumping" patients from State mental hospitals into ICFs, using them as inappropriate alternatives to mental hospital care. The real issue here, however, is whether particular facilities were IMDs. As part of its findings supporting the conclusion that the facilities had the requisite overall character, the Agency found that the facilities had relatively large numbers of patients placed into the facilities from State mental hospitals. None of the State's evidence directly contradicts the Agency's findings, which are based on State census reports. Indeed, given that only small percentages of persons discharged from State facilities were placed in long-term care and that over 400 facilities received some patients, the relatively high number of placements into these facilities has greater weight in showing that these facilities were not typical ICFs than it would otherwise.

Thus, while we find Illinois' evidence sufficient to establish certain facts, those facts are not directly relevant to the issues before us and do not overcome the Agency's findings that high percentages of the patients in the facilities had mental disorders and that the State in some way recognized that the facilities

were primarily serving the mentally ill. Thus, we conclude that the facilities met the regulatory definition and were IMDs.

Accordingly, we sustain the disallowance of $4,261,162 in FFP claimed for services provided in these facilities.

C. Minnesota

Docket Nos. 79-52-MN-BC and 79-89-MN-BC involve disallowances of FFP claimed by the State of Minnesota for services provided to persons under 65 years of age in three ICFs during quarters ending September 30, 1977 through June 30, 1978. The Agency concluded that the three facilities were IMDs based on a review conducted by the Region V Medicaid Bureau.[32] The Agency states that these facilities were selected for review based on a list of facilities with a Minnesota "Rule 36" license for residential facilities providing programs for five or more mentally ill persons. The record indicates, however, that only two of the three facilities had this type of license. MN Review Report, Attachment 8.

1. The Reviewers' Findings in Minnesota

Utilizing methods similar to that employed by the Illinois review team, the reviewers examined Minnesota Department of Public Welfare records that included judgments by the State's medical personnel as to the primary reason for each Medicaid patient being in the facility. Diagnoses of mental diseases were based on the ICDA. The reviewers also considered correspondence from the facilities, statements by Minnesota concerning the facilities, and other information.

The reviewers concluded that all three facilities were "primarily engaged in providing treatment and care for persons with mental diseases." The findings for individual facilities are described below.

Andrew Care Home

90.4% of the Medicaid patients in this facility were found to have diagnoses of mental diseases. In a letter to the Agency

[32] "Report on Review of Federal Financial Participation under Medicaid in Payments for Care in Institutions for Mental Diseases," November 8, 1978 (MN Review Report).

concerning a requested waiver of a handrail requirement, counsel for the home characterized it as follows:

> ". . . the residents of Andrew Care Home are handicapped because of mental health rather than physical disability . . . ."
>
> ". . . only 10% of the total resident population is over 65 years old . . . ."
>
> "The majority of residents of the facility carry a diagnosis of schizophrenia or paranoid schizophrenia or other neurological disorders." MN Review Report, Attachment 10.

In a subsequent letter, the same law firm referred to Andrew Care Home as a "mental health residential facility." MN Review Report, Attachment 11. According to State records cited by the reviewers, the average age of Medicaid patients in the facility in November 1977 was 39.88 years. Andrew Care Home was licensed under Rule 36 from December 1, 1976 to January 1, 1978 and the review report quotes the following statement, concerning the license, made in a memorandum of the Minnesota Department of Public Welfare:

> Rule 36 licensure is a direct admission, being a program license, that the facility has a fairly primary intent to provide specific care and treatment aimed at the mentally ill population.

Birchwood Care Home

86.4% of the Medicaid patients in this facility were found to have diagnoses of mental diseases. The Minnesota Department of Public Welfare in a letter dated December 27, 1977 stated that the average age of Medicaid residents in November 1977 was 58 years. Birchwood Care Home had a Rule 36 license for adult mentally ill persons from March 1, 1977 to March 1, 1978.

Hoikka House

The reviewers found that 94.9% of the Medicaid patients in this facility had diagnoses of mental diseases. The average age of Medicaid patients in November 1977 was 48 years and a

majority of patients came to the house from State hospitals. A calling card of the Hoikka House program director refers to the facility as providing "Care of the Mentally Ill."

2. Discussion of the Issues in Minnesota

a. Availability of Psychiatric Treatment and Diagnostic Services on the Premises

Minnesota argues that the Agency criteria failed to address a critical element of the definition of an IMD by failing to consider the availability of psychiatric treatment at the facilities. Minnesota presented affidavits from administrators of all three facilities, stating that residents did not receive psychiatric or psychological services on the premises of the facility. Any such services received by the patients were furnished outside the facility. The administrators characterize the services provided by the facilities as counseling in "basic living skills" designed to increase patients' capacity to function more independently and to deal with daily living needs.

As we discussed more fully in our section on the regulations, the regulatory definition of an IMD requires that a facility provide "treatment" for its patients, not a specific kind of treatment such as active psychiatric services. The Agency argues that, depending on the individual's condition, counseling in living skills may be just as significant in treating the individual as classic psychiatric therapy. Further, Minnesota does not deny that psychiatric treatment received by residents outside the facilities may complement the services received within the facility and may be considered to be part of the residents' comprehensive treatment program at the facility.

Minnesota also argues that the Agency's criteria are defective in that they do not consider the availability of diagnostic services at the facilities. We have previously addressed several aspects of this issue. The regulations do not require that a facility must provide diagnostic services for mental diseases in order to be classified as an IMD. Moreover, Minnesota has not presented evidence that the facilities here do not diagnose patients upon admission or at some subsequent time.

b. Recorded Diagnoses of Patients as an Indication of Type of Facility

Minnesota also argues extensively that the recorded diagnoses of the patients are not a reliable indicator of the type of facility since misdiagnosis frequently occurs and old diagnoses are not updated. Minnesota adds that the listing used for classifying mental diseases, the ICDA, is indefinite and of limited usefulness. Minnesota ignores the fact, however, that the diagnoses cited here were derived from the State's own records and were used by health professionals in placing and retaining the residents in the facilities under review. Regardless of whether the diagnoses were correct, the facilities apparently depended on them in providing patient treatment and care and in developing their services and programs. Moreover, it would be unreasonable to require the Agency to rediagnose each of the individuals in the facilities under review merely so it could administer the IMD provisions. While Minnesota criticizes the ICDA for lack of definiteness, it does not propose any preferable alternative method of classification.

Minnesota also argues that the key specialist that assisted in the Agency review lacked the background to assess the facilities and to evaluate patient diagnosis. As we understand the review procedures, however, the specialist depended largely on the State's own records. Minnesota does not allege that the statistics cited were inaccurately transcribed. Also, the Agency alleged that its reviewers were assisted by medical personnel when necessary and the State has not disputed this.

c. Other Arguments

The State also raises a series of arguments concerning individual criteria applied by the Agency. The Agency has never asserted that age distribution, former place of treatment, or Rule 36 licensure, if taken alone, would be a decisive indication of the facility's character. The Agency may properly consider these criteria, in our view, if it also considers more conclusive ones such as the facility's own representations and the makeup of the patient population. We certainly would not discount representations made by the facility's counsel relating

to another Medicaid program requirement simply because the facility could "benefit" from the representation.

In conclusion, there is substantial evidence in the record that these facilities met the regulatory definition for IMDs. A very large percentage of the patient population in each of the facilities had diagnoses of mental diseases, and other significant indicators support the Agency's findings in each case. While Minnesota has raised legal arguments concerning the weight to be given to findings, it has not presented any evidence to persuade us that these findings were incorrect.

Accordingly, we sustain the disallowance of $896,159 in FFP claimed for these facilities during quarters ending September 30, 1977 through June 30, 1978.

D. California

Docket No. 80-184-CA-HC involves a disallowance of FFP claimed by the State of California for services provided to persons under 65 years of age in five SNFs during the quarters ended March 31, 1975, through September 30, 1977. Based on an HHS Audit Agency report,[33] the Agency determined that the five facilities were IMDs.

In classifying the facilities as IMDs, the Agency primarily relied on four factors: participation by the facilities in a special State program for the mentally disordered; licensing status; program and admission policies; and patient population. Below we discuss each of these factors, as well as some general arguments the State makes. We conclude that the Agency has presented substantial evidence to show that these California SNFs were IMDs.

1. The Special Disabilities Service Program

In September 1974, the State of California authorized funding for a Special Disabilities Service (SDS) Program, through which a supplemental payment could be made to

[33] "Audit of Five Selected Skilled Nursing Facilities that Participated in California's Special Disabilities Services Program for the Mentally Disordered, February 1, 1975, through September 30, 1977," ACN 00150-09 (CA Audit Report), Exhibit A to CA Supp. to App.

participating SNFs and ICFs for services to persons who were developmentally disabled, substance abusers (alcohol or drugs), or mentally disordered. California Administrative Code, Title 22, Division 5. In order for a facility to be certified for the mentally disordered component of the SDS Program, at least 30 of its patients had to be certified by the local mental health director as having a primary or secondary diagnosis of a mental disorder. CA Audit Report, p. 12. Participation in the SDS Program was used by Agency auditors as an initial screening device in choosing the five facilities in question here.

California does not deny that each of the facilities participated in the program, but attempted to show that it was irrelevant to IMD status. Through testimony, California implied that the fact of participation might be misleading since the SDS Program served the developmentally disabled and substance abusers, as well as the mentally disordered. Tr., pp. 258-262. As part of the administrative record on which it based its decision (Agency Record), however, the Agency has submitted materials which show that each of these facilities qualified for a component of the program called "mentally disordered rehabilitation," and that some of the facilities had more eligible patients than the required number.[34] Agency Record, Tab 16. The State has not challenged the authenticity of these documents. These materials also show that both the facilities and the State referred to the program as a "special treatment" program. This undermines the State's position that the rehabilitation services provided should not be considered "treatment" within the meaning of the IMD regulatory definition.

b. Licensing Status

Another factor relied upon by the Agency auditors in determining IMD status was that the facilities were licensed by the State as skilled nursing facilities, "long-term mental." A California witness testified that this license classification (re-

[34] We do not think it significant that all of the patients were not eligible since the materials indicate that ineligibility may relate to lack of rehabilitation potential rather than to mental status.

ferred to as an "L-facility") was developed for "wandering geriatrics," and some people therefore thought the "L" referred to permission to have a locked door. Tr., pp. 225-226. Yet, the relevant licenses clearly say "long-term mental," and indicate for some facilities that the total bed capacity had that classification and for others that at least half the capacity did. Agency Record, Tab 16.

2. Program and Admission Policies

For their conclusion that the facilities were established and maintained primarily for the care and treatment of persons with mental diseases, the auditors also relied heavily on the facilities' program and admission policies. Some of the most significant statements in these materials, included in the Agency Record at Tab 16, are the following:

Facility A:

> This facility was self-described as having cared for "over 1000 mentally disabled residents" during its 4 and ½ years of experience. Its program was described as "a practical approach at teaching/reteaching the skills of living required for the severely mentally disordered." Patient profiles included "treatment" as the "functional level" which "includes the majority of residents." The program was described as a standard one, varying only "according to the specific patient's treatment plan." A Certification and Transmittal form for Medicaid eligibility of the facility identified as the "certification specialization and/or services" of the facility "mentally disordered/rehabilitation."

Facility B:

> Its own Program Philosophy described this facility as a "120 bed facility comprised primarily of mentally ill patients." An Information Booklet describing participation of the facility in the SDS Program stated that the extra funding "is expended strictly on additional psychiatric and recreational staff members . . . ." Under "Admission Policies" is the following: "Only patients in need of 24 hour skilled nursing services for the management and observation of mental illness or other related behavioral disorders shall be admitted . . . . Patients with only physical illnesses shall not be admitted."

Facility C:

> The admission policy of this facility was described as an intent "to admit patients who exhibited behavior compatible with the State's Special Treatment Program." The philosophy of the facility was "to care for those individuals who have a mental disorder requiring long-term care in a highly structured, secure environment," and the basic program was described as "utilization of behavioral intervention and rehabilitation techniques."

Facility D:

> Facility materials referred to "residents of our long-term psychiatric facilities." Program philosophy was described as "employment of all the latest, medically approved psycho-social treatment modalities." The facility also had "mentally disordered/rehabilitation" as a certification status.

Facility E:

> The admission policy of this facility was to exclude "patients that do not have a primary psychiatric diagnosis." The treatment program was described as "planned for the chronically mentally ill, not the mentally retarded."

California attacked the reliability of this evidence through testimony that it would be to a facility's financial advantage to advertise as a facility specializing in the mentally ill so as to qualify for the SDS Program. Tr., p. 223. We are not inclined on this basis, however, to conclude that these facilities misrepresented themselves, particularly since some of their statements were not purely advertising but related to certification for State programs.

3. Patients' Diagnoses

The points on which California did present some persuasive evidence mostly went to the issue of whether the auditors' findings were reliable with respect to diagnoses of the patients.

The auditors described their method for determining the characteristics of the patient populations of the five SNFs as follows:

> We randomly selected 210 Medicaid claims for each of the five SNFs, or 1,050 sample items in total, for the periods the SNFs participated in the [SDS] Program until September 30, 1977. We then made on-site visits to the five SNFs and reviewed patients' medical records for the periods covered by the paid claims. We obtained the patients' primary and secondary diagnoses and noted if the patients were being treated for physical illnesses or mental diseases. We categorized the patients' diagnoses as mental diseases based on those listed under the heading of Mental Disorders in the [ICDA].
>
> * * *
>
> Our review showed that 1,005, or 95.7 percent, of the claims were for patients with mental diseases and 45, or 4.3 percent, of the claims were for patients who had physical illnesses as their primary diagnoses. CA Audit Report, pp. 15-16.

The auditors' charts show that the auditors included as primary diagnoses of mental diseases the categories alcoholism, schizophrenia, chronic/organic brain syndrome, senility, psychosis, and "other mental diseases." CA Audit Report, pp. 16-17.

California attacks these findings on a number of different grounds, challenging the reliability of the findings as a whole, the specific inclusion of certain diagnoses as mental, and the use of medical records.

California's position is most fully elaborated in a report prepared by a clinical psychologist who is a Senior Mental Health Consultant for the State (Consultant).[35] In her report and testimony at the hearing, this Consultant assessed the results of a study, performed at the request of the State,

---

[35] "Assessment of the Diagnostic Composition of the Patient Population in a SNF Deemed by Federal Auditors To Be an IMD: Further Analysis of Results and Implications for Interpreting the Audit Approach and Findings," Exhibit C to CA Supp. to App. (Consultant's Report).

designed to provide accurate diagnostic characterization of the patients in one of the five SNFs audited (Diagnostic Study).[36]

The Consultant challenges the auditors findings that 95.7% of the sample claims were for patients with mental diseases and only 4.3% were for patients with a primary diagnosis of physical illness. She states: "These proportions strikingly differ from those which would be anticipated on the basis of well-documented, methodologically sound studies of the extent of primary physical diseases in patient populations manifesting mental symptoms." Consultant's Report, p. 47. For this proposition, the Consultant relies on the Diagnostic Study mentioned above and on a "landmark study" which showed a 46% error rate of undiagnosed primary physical disorders in a group of 100 State hospital psychiatric admissions.[37]

While California presents convincing evidence to the effect that misdiagnosis of patients with mental symptoms is prevalent, we are not persuaded that we should therefore apply the 46% error rate to the auditors' findings, as California suggests.

Even though the Agency may have been relying on diagnoses in patients' records which were incorrect, to the extent that these diagnoses were in the records, they are evidence as to the "overall character" of the facilities. The facilities were admitting and treating the patients using those diagnoses. The Agency cannot be expected to perform for each patient the extensive diagnostic analysis which California's own evidence shows is necessary to properly determine whether there is a physical cause of psychiatric symptoms. Moreover, the "landmark study" on which California partially bases its thesis that many of these SNF patients were misdiagnosed is a study of patients in a *State mental hospital.* Therefore, misdiagnosis is hardly a basis for distinguishing these SNFs from recognized IMDs.

---

[36] "Neurobehavioral Evaluation and Diagnostic Study of 102 patients in an 'L' Facility", prepared by Neurobehavioral Foundation, Exhibit B to CA Supp. to App.

[37] "Physical Illness Manifesting in Psychiatric Disease," Hall et al., reprinted in Consultant's Report.

California's Consultant also presents a detailed analysis to show that the auditors did not properly apply the ICDA in classifying patients. The most cogent evidence of this which California presents relates to the categories of senility, alcoholism, and chronic/organic brain syndrome. The State presented expert testimony by a psychiatrist with the California Department of Mental Health (Psychiatrist), who pointed out the difficulties associated with use of the ICDA. He testified that "senility" is not a code in the mental disorders chapter of the ICDA. Tr., p. 183; see also, Consultant's Report, p. 50. California also questioned the auditors' use of the term "alcoholism." According to California's Consultant, there is a code in the ICDA for "alcoholism," meaning either episodic or habitual excessive drinking, as well as a code in the mental disorders chapter for "alcoholic psychoses," which come within the organic mental disorders. Consultant's Report, p. 50. With respect to the category "chronic/organic brain syndrome" (which the Psychiatrist describes as a constellation of symptoms which raises the suspicion that something has gone wrong with the brain itself, Tr., p. 203), California states that the ICDA guidelines require that patients with any organic mental disorder also be coded for the causal or associated physical disease. Consultant's Report, pp. 51-52; Tr. pp. 184, 190. Thus, California concludes that the auditors misused the ICDA.

The Agency did not present any evidence which would show that senility should have been included as a mental disease, although testimony by California's Psychiatrist suggests that this would not always be inappropriate. Tr., p. 183. The Agency also did not fully explain its rationale for inclusion of alcoholism and chronic/organic brain syndrome here. But see, CT Review Report, Attachment F.

The record shows that the State's underlying factual premises have some validity. We do not agree with the State, however, as to the conclusions to be drawn from those premises. California acknowledges that many persons whose diagnoses were senility, alcoholism, or organic brain syndrome were in State mental hospitals in the early sixties. Tr. pp. 116-117; see also, Tr. p. 193. Moreover, even if we were to exclude

patients with these primary diagnoses on the grounds that including them was inconsistent with proper use of the ICDA, the auditors' sample still provides a basis for concluding that over 50% of the patients had mental diseases. Out of the 210 sample claims for each facility, patients placed by the auditors in the categories of schizophrenia, psychosis, and "other mental" total well over 50% of the claims. Excluding the "other mental" category as well would reduce the percentage of patients with primary mental disorders below 50% for one of the facilities only (Facility B). CA Audit Report, p. 17.

We consider it most important, however, that any defects in the auditors' findings here must be viewed in the context of other strong evidence that the facilities had the requisite "overall character." In particular, the facilities' own program and admission policies discussed above support the finding that the facilities were primarily engaged in treating persons with mental diseases.

4. Other Arguments by California

The State also attempts to show the unrealiability of medical records for determining diagnosis and the need for exercise of medical judgment where there is more than one diagnosis. As we have previously mentioned, we think the Agency was reasonable in relying on medical records under these circumstances. Also, while the auditors here certainly do not have the credibility that the Connecticut review team had, the Agency has stated without contradiction that the auditors were advised by a physician-consultant whenever necessary and, in cases of doubt, the audit team would confer with the medical staff of the facility. Cons. Br., p. 9.

We also conclude that the State's remaining arguments do not have merit. The State points out that private-pay patients were not included in the auditors' sample, but has presented nothing to lead us to conclude that the characteristics of these patients would be significantly different from those of the Medicaid patients. This is highly unlikely in view of the facilities' program and admission policies. The State also argued at one point that the auditors presupposed their result and did not do a random sample of all the facilities participating in the SDS Program. The Agency responded that the audit

was performed in accordance with generally accepted principles, that the auditors did not have a "preconceived purpose," and that there was no need for a random sample of all participating SNFs since the disallowance relates to only five of them. Agency Response, Docket No. 80-184-CA-HC, pp. 27-28. California did not press its arguments on these points during the later stages of the proceedings, and we do not find them convincing.

5. Conclusion in California

California has shown that there might have been some defects in the audit here, notably the inclusion of patients with senility. The evidence as a whole, however, convincingly demonstrates that these five facilities had the "overall character" of being IMDs.

Accordingly, we sustain the disallowance of $2,329,401 claimed by the State of California for services provided by these facilities in the quarters ending March 31, 1975 through September 30, 1977.

VI. General Conclusion

For the reasons stated above, we uphold the Agency disallowances in all five appeals considered jointly here.

/s/ Cecilia Sparks Ford
Cecilia Sparks Ford

/s/ Donald F. Garrett
Donald F. Garrett

/s/ Norval D. Settle
Norval D. (John) Settle,
Panel Chair

APPENDIX E

No. 82-1164 and 82-2297

No. 82-1164
STATE OF MINNESOTA, BY ITS COMMISSIONER OF PUBLIC WELFARE, ARTHUR E. NOOT,
Petitioner,

v.

MARGARET M. HECKLER, SECRETARY, AND THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondents.

No. 82-2297
STATE OF MINNESOTA, BY ITS COMMISSIONER OF PUBLIC WELFARE, ARTHUR E. NOOT,
Appellee,

v.

MARGARET M. HECKLER, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Appellant.

Appeal from the United States District Court
for the District of Minnesota.

Petition for Review of Order of Secretary of Department of Health and Human Services.
Filed: September 30, 1983

Submitted: November 8, 1982
Filed: September 30, 1983

Before LAY, Chief Judge, ROSS and FAGG, Circuit Judges.

LAY, Chief Judge.

These cases were consolidated for purposes of resolving issues of subject matter jurisdiction and conflicting interpretations of Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (1976 & Supp. V 1981). The State of Minnesota contests a decision of the Secretary of the United States Department of Health and Human Services (HHS) disallowing federal financial participation to the State under the Medical Assistance Program (Medicaid) for costs incurred in three community residential facilities. The facilities were determined by the Secretary to be "institutions for mental diseases" (IMDs) and thus were not qualified for partial federal reimbursement of medical costs for individuals eligible for Medicaid.

Beginning in 1973, the State of Minnesota paid Medicaid claims for individuals receiving services in the Andrew Care Home, the Birchwood Care Home, and the Hoikka House. The three community residential care homes had been certified as "intermediate care facilities" (ICFs).[1] "Intermediate care facility services" for eligible individuals under 65 are reimbursable under the Act other than such services provided in an institution for tuberculosis or an "institution for mental diseases." *See* 42 U.S.C. § 1396d(a)(15), (18)(B)(1976). The residents of these three homes included a majority of individuals with mental illness diagnoses. During the quarters ending September 30, 1977 through June 30, 1978, Minnesota claimed and was paid $896,159 in federal financial participation for services provided to the Medicaid recipients at these three facilities. In November 1978 the HHS Health Care Financing Administration (HCFA) submitted an audit report which recommended disallowance of the $896,159 claim on the ground that these facilities were IMDs. The agency employed unpublished interpretive guidelines to determine if the "overall character" of the facilities fit the regulatory definition of an IMD as being "primarily engaged in providing diagnosis, treatment or care of persons with mental diseases." *See* 42 C.F.R. § 435.1009(e) (1982); *see also id.* § 440.140(a)(2) (1982). As a result, the Secretary disallowed the State's claim.

[1] In 1982 over 600 Minnesota facilities were certified as "intermediate care facilities."

The State petitioned the HHS Departmental Grant Appeals Board for a review of the decision. Consolidating the petition with requests by the States of Connecticut, California, and Illinois to review similar disallowances, the Board upheld the agency decision. Departmental Grant App. Bd. Nos. 79-52-MN-HC, 79-89-MN-HC, 80-44-IL-HC, 80-150-CT-HC, 80-184-CA-HC (Nov. 30, 1981). HHS recovered the full amount of these funds paid to Minnesota by offsetting federal financial participation in a supplemental grant to the State.

Minnesota filed a petition for direct review of the final agency order with this court; such action was taken to protect the right of review in the event the dispute was determined to be a plan conformity matter under 42 U.S.C. § 1316(a)(3) (1976 & Supp. V 1981),[2] and not a disallowance under 42 U.S.C. § 1316(d) (1976 & Supp. V 1981).[3] The State also

[2] 42 U.S.C. § 1316(a)(3) (1976 & Supp. V 1981) reads in relevant part:

> Any State which is dissatisfied with . . . a final determination of the Secretary under section . . . 1396c of this title may, within 60 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which such State is located a petition for review of such determination.

For operation of state plans, 42 U.S.C. § 1396c (1976) states:

> If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—
>
> (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or
>
> (2) that in the administration of the plan there is a failure to comply substantially with any such provision;
>
> the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

[3] 42 U.S.C. § 1316(d) (1976 & Supp. V 1981) reads as follows:

> (d) Whenever the Secretary determines that any item or class of items on account of which Federal financial participation

(footnote continues)

sought review of the Board's decision in the United States District Court for the District of Minnesota by filing an action for declaratory and injunctive relief as well as restoration of its grant money withheld by HHS.

The district court granted summary judgment in favor of the State of Minnesota, holding that HHS acted arbitrarily, capriciously, and outside the scope of its authority; it ordered HHS to return to the State the disallowed funds. *Minnesota v. Schweiker,* No. 4-82-155, slip op. at 14 (D. Minn. Aug. 25, 1982). HHS now appeals this decision. The two cases were consolidated to resolve the jurisdictional issues and the merits.

I. Plan Conformity or Disallowance.

A fundamental question is whether this dispute involves a noncompliance question or a disallowance. Both the Secretary and the State urge that the matter involves a disallowance and therefore this court has no jurisdiction to directly review the Board's decision. We agree.

Recent decisions from other circuits have taken divergent approaches to assessing the nature of Medicaid controversies. The First Circuit employs a functional analysis which examines three criteria: (1) whether the matter could comfortably fit within the plan conformity language of 42 U.S.C. § 1396c (1976); (b) whether the broad nature of the dispute points to characterization as a conformity issue; and (3) what procedures and label the Secretary has chosen, "not as definitive but as entitled to some respect." *See Massachusetts v. Departmental Grant Appeals Board,* 698 F.2d 22, 27-30 (1st Cir. 1983). *Cf. New Jersey v. Department of Health and Human Services,* 670 F.2d 1262, 1272 (3d Cir. 1981) (*New Jersey I*) (court must independently evaluate underlying substance of dispute so that court of appeals' jurisdiction is not contingent upon Secretary's unfettered discretion); *State Department of Public Welfare v. Califano,* 556 F.2d 326, 330 (5th Cir. 1977), *cert. denied,* 439

(footnote continued)

> is claimed under title . . . XIX . . ., shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance.

U.S. 818 (1978) (court should review Social Security Act, legislative history, and circumstances of claim to see what label best serves purposes of the act and the equities of the situation).

In contrast, the Seventh Circuit found the functional approach "complicated and therefore uncertain in application—a serious weakness in a jurisdictional test." *Illinois v. Schweiker,* 707 F.2d 273, 278 (7th Cir. 1983). Instead, it adopted a literal test which allows HHS' choice of the plan conformity or disallowance label and procedures to control.[4] *Id. Cf. Connecticut v. Schweiker,* No. 82-4023 (2d Cir. April 20, 1982) (without explanation, court of appeals dismissed for lack of jurisdiction a petition for direct review of alleged plan conformity issue; Secretary had denominated the dispute as a disallowance); *Department of Public Health v. Departmental Grant Appeals Board,* No. 81-3341 (6th Cir. Nov. 4, 1981) (same); *Washington Department of Social and Health Services v. Schweiker,* No. 81-7414 (9th Cir. Sept. 30, 1981) (same).[5]

Although some deference is to be accorded the Secretary's opinion on these jurisdictional fact issues, we find the functional test in *Massachusetts v. Departmental Grant Appeals Board,* 698 F.2d at 27-30, is more in accord with the traditional role of federal judicial review which mandates judicial inquiry as to congressional intent, jurisdiction, and the legality of federal administrative actions. *Accord New Jersey I,* 670 F.2d at 1272.

The underlying nature of this controversy stems from the discrete reason that three nursing homes were decertified and thus did not qualify for federal funding. In this regard, the district court correctly observed "[t]his dispute does not concern the validity of Minnesota's Medicaid plan or its overall

[4] The Seventh Circuit panel did interject a caveat to its "clean line" approach, noting that some "safety valve" may be necessary to prevent HHS from evading the scheme of judicial review created by Congress when the practical effect of a disallowance is to shut off all or most of a state's federal financial participation. *Illinois v. Schweiker,* 707 F.2d at 279.

[5] In *Illinois v. Schewiker,* the court stated that it prefers "the simpler approach *apparently followed by the Sixth and Ninth Circuits"* in these cited cases (emphasis added). The court acknowledged that "the Third Circuit has questioned the meaning of these cryptic unpublished orders." *Illinois v. Schweiker,* 707 F.2d at 279. *See also New Jersey I,* 670 F.2d at 1273 n.10.

administration." *Minnesota v. Schweiker*, slip op. at 4-5. Plan conformity issues under the statute, sections 1316(a)(3) and 1396c, generally relate to compliance questions that have a broad impact on the overall state program. We cannot say, under the plan conformity specifications of section 1396c(2), that the State in the administration of its Medicaid plan failed to comply substantially with the provisions of 42 U.S.C. § 1396a (1976 & Supp. V 1981). The decertification here is basically rooted in a failure to comply with an agency interpretive guideline.[6] In addition, the claim arises out of the disallowance procedures involving a specific audit, and only a retroactive, not prospective, sanction was imposed.[7] We thus conclude that the dispute clearly relates to a disallowance rather than a conformity issue. *Accord Connecticut v. Schweiker*, No. 82-4023 (2d Cir. Apr. 20, 1983); *Connecticut v. Schweiker*, 557 F. Supp. 1077, 1079 & n.5 (D. Conn. 1983).

II. Jurisdiction of District Court.

Although section 1316(a)(3) grants a state dissatisfied with a plan conformity decision the right to direct review in a court of appeals, the provision for disallowances, section

[6] It is unclear under 42 U.S.C. § 1396(1), (2) (1976) whether a plan conformity issue can pertain not only to a state's substantial failure to comply with a federal statutory plan requirement, 42 U.S.C. § 1396a (1976 & Supp. V 1981), but also to a state's substantial failure to comply merely with a federal regulation or the state's own plan. *Massachusetts v. Departmental Grant Appeals Board*, 698 F.2d at 28-29 & nn. 5 & 7. HHS has specified that a plan conformity issue may arise from the failure of a state in practice to comply with "a Federal requirement." 45 C.F.R. § 201.6(a) (1982). *Compare Department of Public Health v. Departmental Grant Appeals Board*, No. 82-3760, slip op. at 2 (6th Cir. May 9, 1983) (disallowance, not conformity issue, found; state in "non-compliance with regulatory rather than statutory requirements") *with New Jersey I*, 670 F.2d at 1266-77 (plan conformity issue found although noncompliance was only with a federal requirement in a "program instruction"); *and Solomon v. Califano*, 464 F. Supp. 1203, 1206-08 (D. Md. 1979) (plan conformity found although noncompliance was only with state's plan).

[7] Administrative procedures governing federal audit agency issues are set forth in 45 C.F.R. § 201.10-.66 (1982).

1316(d), is silent as to the availability of judicial review for such disputes.[8]

We agree with the courts that have found that disallowance decisions under section 1316(d) are judicially reviewable. *Illinois v. Schewiker*, 707 F.2d at 275-277; *Alameda v. Weinberger*, 520 F.2d 344, 347-48 (9th Cir. 1975); *Colorado Department of Social Services v. Department of Health and Human Services*, 558 F. Supp. 337, 347-48 (D. Colo. 1983); *Connecticut v. Schweiker*, 557 F. Supp. at 1079. *Cf. Solomon v. Califano*, 464 F. Supp. 1203 (D. Md. 1979) (court reviewed disallowance decision without discussing jurisdiction); *Georgia v. Califano*, 446 F. Supp. 404 (N.D. Ga. 1977) (same). *Contra State Department of Public Welfare v. Califano*, 556 F.2d 326, 329 n.4, 332 (5th Cir. 1977), *cert. denied*, 439 U.S. 818 (1978) (dictum).

Although the district court has jurisdiction to review this disallowance, the court's power is limited to granting prospectively-oriented declaratory relief. We must vacate the district court's money award restoring past disallowance funds since jurisdiction for this claim is exclusively in the United States Claims Court.[9]

The exclusive jurisdiction of the Claims Court applies to monetary claims in excess of $10,000 against the United States and its agencies. 28 U.S.C. § 1491 (1976 & Supp. V 1981).[10] Since 1972, the Claims Court also can grant limited equitable relief collateral to a monetary award in order to resolve an

[8] HHS does not contest the district court's jurisdiction to review a disallowance decision. It has previously taken an opposite position. *See Alameda v. Weinberger*, 520 F.2d at 347-48.

[9] We raised the issue sua sponte whether exclusive jurisdiction over both monetary and nonmonetary claims lay in the United States Claims Court.

[10] 28 U.S.C. § 1491 (1976 & Supp. V 1981) states in relevant part:

> The Court of Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort. . . . To provide an entire remedy

(footnote continues)

entire controversy. *See id.; Polos v. United States,* 556 F.2d 903, 906 (8th Cir. 1977); *Melvin v. Laird,* 365 F. Supp. 511, 516-20 (E.D.N.Y. 1973).

If the declaratory or injunctive relief a claimant seeks has significant prospective effect or considerable value apart from merely determining monetary liability of the government, the equitable relief sought is paramount and the district court may assume jurisdiction over the nonmonetary claims.[11] *See Giordano v. Roudebush,* 617 F.2d 511, 514-15 (8th Cir. 1980);

(footnote continued)

and to complete the relief afforded by the judgment, the court may, as an incident of and collateral to any such judgment, issue orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records, and such orders may be issued to any appropriate official of the United States. In any case within its jurisdiction, the court shall have the power to remand appropriate matters to any administrative or executive body or official with such direction as it may deem proper and just.

Cf. 28 U.S.C. § 1346(a)(2) (1976 & Supp. V 1981) (district court has concurrent jurisdiction to grant monetary relief on claims under $10,000).

[11] A split of authority exists on the issue whether the district court can assume jurisdiction over equitable claims based on the same facts as monetary claims when the Claims Court also has the power to grant the nonmonetary relief. Some courts, including this circuit, have found the equitable jurisdiction of the district court concurrent with the Claims Court when the nonmonetary relief is deemed "primary." *See, e.g., Giordano v. Roudebush,* 617 F.2d 511, 515 (8th Cir. 1980); *Stanley v. Commissioners,* 505 F. Supp. 63, 65 (W.D. Mo. 1980); *Bruzzone v. Hampton,* 433 F. Supp. 92, 95-96 (S.D.N.Y. 1977); *Melvin v. Laird,* 365 F. Supp. at 518. *But cf. Keller v. Merit Systems Protection Board,* 679 F.2d 220, 223 (11th Cir. 1982) (distinguished *Giordano* because monetary claim was less than $10,000 at time complaint was filed and thus was within district court's statutory jurisdiction). This approach is supported by legislative history indicating that the grant of collateral equitable jurisdiction to the Claims Court in 1972 was intended only to provide an alternative option for litigants to obtain complete relief in one court if they so desired, and was not intended to oust the district court's declaratory judgment and mandamus jurisdiction. *See Melvin v. Laird,* 365 F. Supp. at 516-19.

Other courts adhere to the view that the nonmonetary jurisdiction of the Claims Court is exclusive, and that the district court may not exercise

(footnote continues)

Megapulse, Inc. v. Lewis, 672 F.2d 959, 971 (D.C. Cir. 1982); *Rowe v. United States,* 633 F.2d 799, 801-02 (9th Cir. 1980), *cert. denied,* 451 U.S. 938 (1981); *cf. Sellers v. Brown,* 633 F.2d 106, 108 (8th Cir. 1980), *cert. denied,* 451 U.S. 938 (1981). The fact that a suit for nonmonetary relief in the district court may also provide a basis for a grant of money damages against the United States is not a sufficient reason to foreclose district court jurisdiction. *See Duke Power Co. v. Carolina Environmental Study Group, Inc.,* 438 U.S. 59, 71 n.15 (1978); *Laguna Hermosa Corp. v. B.E. Martin,* 643 F.2d 1376, 1379 (9th Cir. 1981); *Melvin v. Laird,* 365 F. Supp. at 520; *see also Beller v. Middendorf,* 632 F.2d 788, 799 (9th Cir. 1980), *cert. denied,* 452 U.S. 905 (1981). However, the power of the district court in these types of cases is limited; sovereign immunity of the United States is waived in the district court under 5 U.S.C. § 702 (1982) only for claims against a federal agency or its officers seeking relief "other than money damages." *See United States v. Mitchell,* 51 U.S.L.W. 4999, 5005 & n.32 (June 27, 1983); *Jaffee v. United States,* 592 F.2d 712, 718-19 (3d Cir. 1979). *See generally* K. Davis, *Administrative Law Treatise* § 27.00-.10 (Supp. 1980 & 1982). This jurisdictional limitation results in a bifurcation of claims between the district court and the Claims Court, because the district court is unable to grant monetary relief on claims over $10,000. *See Giordano v. Roudebush,* 617 F.2d at 514-15; *Laguna Hermosa Corp. v. B.E. Martin,* 643 F.2d at 1379 (9th Cir. 1981); *Rowe v. United States,* 633 F.2d at 801-02; *Beller v. Middendorf,* 632 F.2d at 799; *Melvin v. Laird,* 365 F. Supp. at 518-19. *But cf. Woodland Nursing Home Corp. v. Califano,* 487 F. Supp. 9, 11-13 (S.D.N.Y. 1979) (district court with jurisdiction over nonmonetary claim can exercise pendent jurisdiction over monetary claim to provide a " 'common sense solution' " for complete relief in one court). Such bifurcation is unavoidable when the Claims Court lacks the power to grant the type of

(footnote continued)

concurrent equitable jurisdiction regardless of whether the equitable relief sought may be categorized as "primary." *See, e.g., Keller v. Merit Systems Protection Board,* 679 F.2d at 222-23; *Denton v. Schlesinger,* 605 F.2d 484, 486-88 (9th Cir. 1979); *Shaw v. Pierce,* 534 F. Supp. 735, 738-39 (E.D. Cal. 1982).

declaratory or injunctive relief sought. *See Rowe v. United States*, 633 F.2d at 801-02; *Shaw v. Pierce*, 534 F. Supp. at 738. *Contra Woodland Nursing Home Corp. v. Califano*, 487 F. Supp. at 11-13.

Under the facts involved in this dispute, the disallowance is rooted in the federal agency's guidelines interpreting the meaning of the statutory phrase "institution for mental diseases." The guidelines have an effect upon current and future federal benefits to the State in addition to past federal financial participation. The State estimates that potentially over $10 million in federal funds to the State of Minnesota are at stake here, representing not only past claims collected but other claims foregone when Minnesota stopped submitting further claims after the disallowances in 1978 to avoid risking additional losses. The potential current and future claims foregone dwarf the amount of the disallowance the State seeks to have overturned. Although the Claims Court possesses the jurisdiction necessary to make a legal ruling upon which to base the award of a money judgment, *see Pauley Petroleum Inc. v. United States*, 591 F.2d 1308, 1315 (Ct. Cl.), *cert. denied*, 444 U.S. 898 (1979), the declaratory relief sought here has conspicuous impact beyond establishing a right to the disallowed funds.[12] The prospective, independent significance of the declaratory relief requested makes it, not the compensatory

[12] The other relief requested by the State of Minnesota for an order to restore the disallowed funds and for a permanent injunction barring future recovery of that money only relates to the monetary compensation desired by the State for the disallowance. Claims essentially seeking monetary relief over $10,000 fall within the Claims Court's exclusive jurisdiction which may not be evaded by framing a claim for injunctive relief or by requesting the exercise of mandamus jurisdiction. *See Portsmouth Redevelopment and Housing Authority v. Pierce*, 706 F.2d 471, 474 (4th Cir. 1983); *Polos v. United States*, 556 F.2d 903, 905 n.5 (8th Cir. 1977); *Wingate v. Harris*, 501 F. Supp. 58, 61-62 (S.D.N.Y. 1980) (Medicaid disallowance); *State Department of Public Welfare v. Califano*, 388 F. Supp. 1304, 1308 (W.D. Tex. 1975) (state Medicaid claim), *modified in part on other grounds*, 556 F.2d 326, 332 (5th Cir. 1977), *cert. denied*, 439 U.S. 818 (1978). *But see Minnesota v. Weinberger*, 359 F. Supp. 789, 791-92 (D. Minn. 1973) (mandamus power

(footnote continues)

money payments, the primary relief sought by the State of Minnesota.[13] Therefore the district court had jurisdiction over the nonmonetary claims under 28 U.S.C. § 1331 (1976 & Supp. V 1981) and 28 U.S.C. § 2201 (1976 & Supp. V 1981).[14]

(footnote continued)

authorized order of payment by federal agency to state for claim under Social Security Act).

Furthermore, an injunction is inappropriate when the injury can be redressed fully by an award of damages. *E.g., Wingate v. Harris*, 501 F. Supp. at 62. Likewise, the exercise of mandamus power is not properly invoked when another adequate remedy is available. *Id.; State Department of Public Welfare v. Califano*, 388 F. Supp. at 1308.

This case is unlike the situation in *State Highway Commission v. Volpe*, 479 F.2d 1099, 1104, 1123 (8th Cir. 1973), where injunctive relief to cease unauthorized action would automatically make benefits available. In contrast, affirmative action barred by the doctrine of sovereign immunity would be required to produce essentially compensatory payments to the State of Minnesota. *See Johnson v. Mathews*, 539 F.2d 1111, 1124 n.21 (8th Cir. 1976).

[13] In contrast, a dispute over a Medicaid disallowance in *Wingate v. Harris*, 501 F. Supp. 58, 60-62 (S.D.N.Y. 1980), principally involved monetary relief and thus fell within the exclusive jurisdiction of the Claims Court. The district court categorized the requested declaratory and injunctive relief as ancillary under the facts involved, reasoning:

> While it is true that plaintiffs seek several "declarations" regarding the invalidity of various HEW regulations and the illegality of the Secretary's actions thereunder, this relief is merely incidental to the primary remedy requested: an order directing payment of the monies withheld by the Secretary. The declaratory relief sought simply establishes plaintiffs' legal entitlement to this principal remedy, and does not expand it in any meaningful way. . . . *Nowhere . . . is it alleged that this regulation is in current use to deprive plaintiffs of any benefit.* Rather, the gist of their claim is that its *application in the past* with respect to the three nursing homes discussed above operated to deprive them of federal funds to which the Act entitled them. This claimed injury can be redressed fully by an award of damages. . . .

Id. at 62 (emphasis added).

[14] It is apparent that cooperation from HHS would obviate the need for the state to bring a separate suit in the Claims Court to obtain monetary relief for the funds disallowed here. *Cf. Connecticut v. Schweiker*, 557 F. Supp. at 1091 ("This court trusts that HHS . . . will promptly restore any setoff already taken. An injunction is therefore unnecessary.").

III. The Merits.

In deciding that the three facilities in question were "institutions for mental diseases" (IMD) under agency interpretive guidelines, the HHS' Departmental Grant Appeals Board reached conclusions of both fact and law. The agency's formal findings of fact will be upheld if supported by substantial evidence in the record considered as a whole. *See Citizens To Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 414-15 (1971); *Volkswagenwerk Aktiengesellschaft v. Federal Maritime Commission*, 390 U.S. 261, 272 (1968); *Consolo v. Federal Maritime Commission*, 383 U.S. 607, 619-21 & n.19 (1966); 5 U.S.C. § 706(2)(E) (1982); *see generally* K. Davis, *supra*, §§ 29.01-.11 (1958 & Supp. 1980 & 1982).

In contrast, the agency's guidelines interpreting a statutory term and a regulation ultimately involve questions of law which are to be resolved by the court. *See Batterton v. Francis*, 432 U.S. 416, 424-26 & n.9 (1977); *Social Security Board v. Nierotko*, 327 U.S. 358, 368-69 (1946); *White Industries, Inc. v. Federal Aviation Administration*, 692 F.2d 532, 534 (8th Cir. 1982); 5 U.S.C. § 706 (1982). "Ordinarily, administrative interpretations of statutory terms are given important but not controlling significance." [15] *Batterton v. Francis*, 432 U.S. at 424; *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944). *Research Medical Center v. Schweiker*, 684 F.2d 599, 602 (8th Cir. 1982); *see generally* K. Davis, *supra*, § 30.13.

---

[15] The unpublished interpretive guidelines in question here do not reflect an exercise of expressly delegated congressional authority to prescribe substantive standards for determining the meaning of the statutory phrase "institution for mental diseases." *Compare General Electric Co. v. Gilbert*, 429 U.S. 125, 141-45 (1976); *Morton v. Ruiz*, 415 U.S. 199, 236-37 (1974); *Social Security Board v. Nierotko*, 327 U.S. at 369 ("Except as such interpretive power may be included in the agencies' administrative functions," Congress did not delegate to the Social Security Board power to define the statutory term.) *with Herweg v. Ray*, 455 U.S. 265, 274 (1982) (When a term in the statute is followed by a phrase such as "as determined in accordance with standards prescribed by the Secretary," definitional regulations are to be given legislative effect.); *Schweiker v. Gray Panthers*, 453 U.S. 34, 37, 43-44 (1981) (same); *Batterton v. Francis*, 432 U.S. at 424-26 & n.9 (1977) (same).

As in all cases focusing on statutory construction, we must initially look to the language chosen by Congress. *American Tobacco Co. v. Patterson*, 456 U.S. 63, 68 (1982); *Bread Political Action Committee v. Federal Election Committee*, 455 U.S. 577, 580 (1982). The ordinary meaning of the words used are [sic] presumed to express congressional purpose; thus, absent clearly expressed legislative intention to the contrary, the language is regarded as conclusive. *American Tobacco Co. v. Patterson*, 455 U.S. at 68.

The Medicaid statute defines federal "medical assistance" for needy individuals to include, among other items, "intermediate care facility services *(other than such services in an institution for* tuberculosis or *mental diseases)* for individuals who are determined . . . to be in need of such care." 42 U.S.C. § 1396d(a)(15) (1976) (emphasis added). The identical exclusion for services in an IMD is repeated in sections granting medical assistance for "inpatient hospital services" and "skilled nursing facility [SNF] services." *Id.* § 1396d(a)(1), (4A). A correlating section, however, allows payments for "inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over, in an institution for tuberculosis or *mental diseases.*" *Id.* § 1396d(a)(14) (emphasis added). Additionally, the statute provides for funds for "inpatient psychiatric hospital services for individuals under age 21." 42 U.S.C. § 1396d(a)(16) (1976 & Supp. 1981). The statutory definition of "medical assistance" clarifies the prohibition against payments for individuals between age 21 and 65 in an IMD: "[E]xcept as otherwise provided in paragraph (16) [inpatient psychiatric services for individuals under age 21], such term ["medical assistance"] does not include . . . any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient *in an institution for* tuberculosis or *mental diseases.*" *Id.* § 1396d(a)(18)(B) (emphasis added).

Of significance here is the statutory definition of an ICF:

> [T]he term "intermediate care facility" means an institution which (1) is licensed under State law to

> provide, on a regular basis, *health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board)* which can be made available to them only through institutional facilities .... The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements of the [preceding] sentence .... With respect to services furnished to individuals under age 65, the term "intermediate care facility" shall not include, except as provided in subsection (d) of this section,[16] any *public institution* or distinct part thereof *for mental diseases or mental defects.*

Id. § 1396d(c) (emphasis added).

Conspicuously omitted from section 1396d is any statutory characterization of an "institution for mental diseases." The Secretary, however, has promulgated a regulation defining an IMD:

> "Institution for mental diseases" means an institution that is *primarily engaged in providing diagnosis, treatment or care of persons with mental diseases,* including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its *overall character* as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

42 C.F.R. § 435.1009e (1982) (emphasis added). *See also id.* § 440.140(a)(2).

[16] The reference to "subsection (d)" allows medical assistance for ICF services in a "public institution (or distinct part thereof) for the mentally retarded ... receiving active treatment." 42 U.S.C. § 1396d(d) (1976).

The consistency of this regulation with the statute is not contested here.[17] What is attacked is the agency's finding that the three facilities in question are IMDs based on HHS' interpretation of this regulation. Certain unpublished agency guidelines were employed to determine the overall character of these facilities as IMDs. The operating guidelines were developed in response to perceived problems of deinstitutionalization whereby some patients between 21 and 65 years old in state mental hospitals, for which federal Medicaid payments were not obtainable, were relocated by the states in community-based residential facilities, such as ICFs, for which federal funds were available. HHS circulated intra-office instructional bulletins to assist federal field office personnel in their determinations as to the "overall character" of a facility. The following criteria identifying IMDs were used:

> 1. A facility is licensed as a mental institution;
>
> 2. It advertises as a mental institution;
>
> 3. More than 50 percent of the patients have a disability in mental functioning [as defined in the *International Classification of Diseases*];
>
> 4. It concentrates on managing patients with behavior or functional disorders and is used largely by mental hospitals for alternati care;
>
> 5. It is under the jurisdiction of the mental health authority;
>
> 6. It is frequently or predominantly used for individuals who are either discharged from mental hospitals or would otherwise be admitted to them;
>
> 7. The facility is in proximity to a State Mental Institution (for example, within a 25-mile radius);
>
> 8. The age distribution is uncharacteristic of nursing home patients; and

[17] *See* 42 U.S.C. § 1302 (1976 & Supp. V 1981) (providing that the Secretary "shall make and publish such rules and regulations, not inconsistent with this Chapter, as may be necessary to the efficient administration of the functions with which ... [she] is charged under this Chapter").

9. The basis of Medicaid eligibility for patients under 65 is a mental disability.

Letter from Tera S. Younger, HCFA Long Term Care Policy Group, to B. F. Simmons (Nov. 3, 1980) (with Discussion Paper: *Redefinition on Institution for Mental Diseases* attached). *See* HHS Field Staff Information and Instruction Series (FSIIS) FY-76-156 (Sept. 14, 1976); FY-76-97 (May 3, 1976); FY-76-44 (Nov. 7, 1975).

The State of Minnesota asserts that these criteria interpreting the IMD regulation conflicts [sic] with the Medicaid provisions of the Social Security Act and with agency regulations. The State contends that if a definition consistent with the statute had been applied, the three facilities would not have been classified as IMDs. It urges that Congress intended the phrase "institution for mental diseases" to apply only to state mental hospitals, or alternatively, that the term applies only to institutions whose primary purpose is to provide specialized care or services for mental illness. Thus, the State contends, inquiry into whether a facility is an IMD must focus on the nature of services that the facility renders, not on the diagnosis or type of illness manifested by the patient. It stresses, for example, that the use of the "51% rule" based on the number of patients in a home with diagnoses of mental diseases is a particularly inappropriate and arbitrary factor under the statute.

The agency defends its position by pointing to the statutory section 1396d(a) which lists hospital services separately from SNF and ICF services, and then excludes from payment all three types of services in an IMD. Thus, it says, all IMDs are not traditional mental hospitals. Under its view, the term IMD must be able to include SNFs and ICFs or else the word "hospital" would be superfluous because of being incorporated into the term IMD. HHS argues that the Board's decision upholding the disallowance was rationally based, that the guideline criteria were rationally related to identification of an IMD, and that no one criterion was determinative. It finds the State's argument against the "51% rule" unfounded here when at least 86% of the patients at each of the three facilities had diagnoses of a mental disease. It maintains that adoption of

Minnesota's position focusing on type of care given would result in rewarding facilities which do not provide the services required by patients' diagnoses.

We hold that the Board's interpretation of its regulation defining an IMD, and its extensive reliance on diagnoses-based criteria for the purpose of revealing the overall character of an IMD, were inconsistent with the provisions and purposes of the Social Security Act. *Accord Connecticut v. Schweiker*, 557 F. Supp. 1077, 1091 (D. Conn. 1983). We find that the characterization of an IMD must fundamentally center on the type of care or nature of services required, not on the mere presence in a facility of patients who have, or at one time did have, diagnoses of a mental disease. Thus, because insufficient fact finding was performed on the proper basis, we hold that the Board's decision upholding the disallowance was not supported by substantial evidence on the record as a whole.

Our conclusion is rooted in the language of section 1396d defining "medical assistance," and is supported by legislative history as well as other statutory provisions of the Social Security Act. The skeletal framework of allowable "medical assistance" payments in section 1396d(a) is built around various types and levels of care; the section specifies payments for "inpatient hospital *services*," "skilled nursing facility *services*," "intermediate care facility *services*," "inpatient psychiatric hospital *services*," and so on. 42 U.S.C. § 1396d(a)(1), (4)(A), (15), (16) (1976). The statute specifies payments for "intermediate care facility *services . . . for individuals* who are determined, in accordance with section 1396a(31)(A) of this title, to be *in need of such care*."[18] 42 U.S.C. § 1396d(a)(15) (1976) (emphasis added).

---

[18] Likewise, the definitions of "inpatient hospital services for individuals under age 21," "skilled nursing facility services," and ICF care for the mentally retarded all center on the nature of care required by patients. The term "inpatient psychiatric hospital services for individuals under age 21" includes only "*active treatment . . . necessary on an inpatient basis* and can reasonably be expected to improve the condition, by reason of which *such services are necessary, to the extent that eventually such services will no longer be necessary.*" 42 U.S.C. § 1396d(h)(1)(B) (1976) (emphasis added).

(footnote continues)

Section 1396d(c) defining an "intermediate care facility"[19] supplies manifest clarification not only of what an ICF is, but more importantly for our purposes, how an IMD is and is not to be exclusively characterized. The ICF definition expressly authorizes care of patients in an ICF with diagnoses of either "mental or physical condition[s]" as long as the illnesses involved "require" a lesser "'degree of care and treatment" than a hospital or SNF provides.[20] *Cf. Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980) (statutory limitations for IMDs "do not apply to mental health problems in general").

The legislative history of the IMD exclusion and ICF coverage reinforces the statutory language that Medicaid benefits cannot be denied solely on the ground that an institution primarily serves mental patients and that the paramount criterion for distinguishing an IMD from an ICF must be the degree of care and treatment required by patients. The limitation in the Social Security Act for patients in an "institution for mental diseases" was first enacted in 1950 based on the reason that "'long-term care in such hospitals had traditionally been accepted as a responsibility of the States.'" *Schweiker v. Wilson*, 450 U.S. 221, 237 n.19 (1981); *see id.* at 225 n.5. A House report in 1963 stressed the deficiencies of the "State

---

(footnote continued)

The term skilled nursing facilities means "services which are or were required to be given an individual who needs or needed on a daily basis skilled nursing care . . . or other skilled rehabilitation services." *Id.* § 1396d(f).

As to care for the mentally retarded, section 1396d(d) states:

> The term "intermediate care facility services" may include *services* in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—
>
> (1) *the primary purpose* of such institution (or distinct part thereof) *is to provide health or rehabilitative services* for mentally retarded individuals and . . .
>
> (2) *the mentally retarded individual . . . is receiving active treatment* under such a program . . . .

Id. (emphasis added).

[19] *See supra* p. 15-16.

[20] Many persons within an ICF may be deaf or blind or have other physical ailments in conjunction with associated mental problems.

mental institutions": "Only a small percentage of the institutions can be said to be therapeutic and not merely custodial. In 1959, there . . . [was] less than 1 psychiatrist for 500 patients." H.R. Rep. No. 694, 88th Cong., 1st Sess. 11, *reprinted in* 1963 U.S. Code Cong. & Ad. News 1054, 1064.

In contrast, the Medicaid program, which was enacted as Title XIX of the Social Security Act in 1965, was "designed to alleviate the cost of health care which is active and remedial rather than custodial in nature." *Legion v. Richardson*, 354 F.Supp. 456, 459 (S.D.N.Y.), *aff'd sub nom. Legion v. Weinberger*, 414 U.S. 1058 (1973); *accord Woe v. Matthews*, 408 F. Supp. 419, 425 n.16 (E.D.N.Y. 1976), *aff'd mem. sub nom. Woe v. Weinberger*, 562 F.2d 40 (2d Cir. 1977), *cert. denied* 434 U.S. 1048 (1977). The purpose of Title XIX is expressly decreed "to furnish . . . medical assistance . . ., rehabilitation and other services to help . . . individuals attain or retain capability for independence or self-care." 42 U.S.C. § 1396 (1976).

Congress recognized the "great strides in the field of mental disease" which allowed the development of mental health programs "to cure the patients and release them from the institutions, instead of requiring them to spend the rest of their lives in them." 111 Cong. Rec. 21, 348-49 (1964) (statements of Sen. Long). Congress thus authorized exceptions to the IMD exclusion in 1965 for the mentally ill in general medical facilities and for individuals age 65 and over in IMDs.[21] However, the exceptions were granted on the condition that the states arrange with IMDs to develop alternative methods of care for all mental patients, "particularly for the aged who are mentally ill." S. Rep. No. 404, 89th Cong., 1st Sess. 146, *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 2085; *see Connecticut v. Schweiker*, 557 F. Supp. at 1083 n.13,

---

[21] In discussing the bill removing the exclusion for those over age 65, Senator Carlson observed: "Whether an individual of advanced years is merely senile or has a mental disease is a fine line and it may be appropriate for him at one time to be in a mental institution and at another to be in a nursing home, his own home, or in some other arrangement." 111 Cong. Rec. 21, 349 (1964). Appropriate patient placement was thus a motivating factor in removing the IMD exclusion for those age 65 and over. *Accord Connecticut v. Schweiker*, 557 F. Supp. at 1083 n.13.

1084 n.15. This legislation, requiring "plans for the use of other methods of care, such as nursing homes, short-term care in general hospitals, foster family care, and others," besides the standard "[i]nstitutional treatment and care in the individual's own home," was intended to "give further encouragement to the trend in the States for discharging from mental hospitals to the community the aged who are considered able to care for themselves, under some form of protective arrangements." S. Rep. No. 404, 89th Cong., 1st Sess. 146, *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 2085. *See* 42 U.S.C. § 1396a(a)(20), (21) (1976 & Supp. V 1981).

ICF coverage was added to the Medicaid provisions in 1971 and was explicitly intended for persons who "in the absence of intermediate care would require placement in a skilled nursing home *or mental hospital.*" Report of Senate Finance committee, printed in Statement of Sen. Long, 117 Cong. Rec. 44721 (1971) (emphasis added). The development of ICFs was a direct response to the congressional aim of providing the most appropriate placement required by a patient's physical or mental health needs. The committee report on ICFs stressed the concern that "each patient for whom Federal funds is provided is in the right place at the right time receiving the right care .... Each skilled nursing home, each mental hospital patient, and each intermediate care patient must be individually reviewed by an independent team to assure proper placement." *Id.* The report recited the congressional desire to "provide a less costly institutional alternative" than "skilled nursing home care" for patients who needed care "less extensive than skilled nursing home care." *Id.* [22]

[22] In 1972, Congress "further broadened Medicaid benefits for the mentally ill to include most children in mental institutions." *Schweiker v. Wilson*, 450 U.S. at 226 n.5. *See* 42 U.S.C. § 1396d(a)(16) (1976 & Supp. V 1981) ("inpatient psychiatric hospital services for individuals under age 21"). Congress simultaneously defeated a Senate proposal for demonstration projects to evaluate the "potential social and economic benefits of extending medicaid inpatient mental hospital coverage to mentally ill persons between the ages of 21 and 65." S. Rep. No. 1230, 92d Cong., 2d Sess. 280-81 (1972); *see* H.R. Conf. Rep. No. 1605, 92d Cong., 2d Sess. 65, *reprinted in* 1972 U.S. Code Cong. & Ad. News 4989, 5398.

The impropriety of focusing upon a diagnosis of mental illness is also supported by congressional directives prohibiting discrimination on the basis of diagnosis, 42 U.S.C. § 1396a(a)(10) (1983), or handicap, 29 U.S.C. § 794 (1976 & Supp V 1981).[23] An HHS Medicaid regulation in accord declares that a "Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service ... to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c) (1982).[24]

In a recent case involving eligibility for Supplemental Security Income benefits which were tied into Medicaid eligibility, the Supreme Court determined that the exclusion of benefits to any "inmate of a public institution" could not be classified directly on the basis of a diagnosis relating to mental health. *Schweiker v. Wilson*, 450 U.S. at 224-25, 231. Congress, the Court said, distinguished not between the mentally ill and a group composed of nonmentally ill, but between residents in public institutions receiving Medicaid funds for their care and residents in such institutions not receiving Medicaid funds. *Id.* at 232-33.

Unlike the situation in *Wilson*, however, here the stipulated criteria directly classify by mental diagnoses in order to determine whether an institution should receive Medicaid funds.

By its very nomenclature, a threshold requirement for an "institution for mental diseases" must be the presence of patients with a mental disease. However, most of the interpretive criteria in dispute here directly pertain to the mere

[23] HHS regulations under section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1976) define "handicap" to include any mental disorder. *See* 45 C.F.R. § 84.3(j) (1982).

[24] The State's brief quotes statements of HHS in the early 1970's that "'[f]ederal sharing with the States is available for the cost of most types of care for the mentally ill because Title XIX prohibits elimination of patients from the program on the basis of diagnosis.'" Brief for petitioner at 30, *quoting* Social Security Administration, Office of Research and Statistics, U.S. Dept. of H.E.W., Research Report No. 37, Financing Mental Health Care Under Medicare and Medicaid 39 (1971).

existence of present or past mental disabilities of the patients in a facility. When HHS interprets the major distinctive features of an IMD to turn on this factor, it negates a portion of the statute by encroaching upon the intended role Congress determined intermediate care facilities were designed to serve.[25] An agency's interpretation of its own regulations cannot emasculate the plain meaning of the governing statute. *See United States v. Menasche,* 348 U.S. 528, 538-39 (1955).

We do not find it necessary to explore fully the degree of care and treatment that only placement in an IMD can provide. It certainly includes treatment similar to "inpatient psychiatric hospital services" as defined for individuals under age 21 in section 1396d(h)(1)(B). *See supra* note 18; 42 U.S.C. § 1396d(a)(16) (1976 & Supp. V 1981). Legislative history is clear that in allowing such coverage for children, Congress intended to make an exception to the under-age-65 IMD exclusion. S. Rep. No. 1230, 92d Cong., 2d Sess. 280-81 (1972); *see Kantrowitz v. Weinberger,* 388 F. Supp. 1127, 1129-30 (D.D.C. 1974), *aff'd,* 174 U.S. App. D.C. 182, 530 F.2d 1034, *cert. denied,* 429 U.S. 819 (1976); *cf.* 42 C.F.R. § 440.140(a)(ii) (1982) (IMDs must meet general requirements of a psychiatric hospital to be included in Medicaid

[25] The agency itself has expressed doubts as to the validity and effectiveness of some of the guidelines. A Discussion Paper of "Redefinition On Institution For Mental Diseases" observed:

> These guidelines lack regulatory force and contain some criteria that are of questionable applicability in determining whether a facility is an IMD, e.g., whether the facility is located within a 25-mile radius of a State mental hospital . . . . [W]e believe that objective criteria for identifying an IMD need to be incorporated into the regulations. We exercised [sic] the possibility of incorporating criteria related to the percentage of mentally ill individuals in skilled nursing facilities and intermediate care facilities. *We have reservations about this, however, because the criteria (particularly the numerical criterion) do not necessarily indicate the nature of the services being furnished by the facility* and enforcement may provide an undesirable incentive for substitution of nonpsychiatric diagnoses and transfer of patients to avoid reaching the guideline percentile.

Letter from Tera S. Younger, HCFA Long Term Care Policy Group, to B. F. Simmons (Nov. 3, 1980) (Discussion Paper attached) (emphasis added).

coverage for those over age 64). IMD treatment may thus include a higher degree of care and treatment than is provided by facilities which only offer SNF or ICF services. However, based on legislative history, it also may include custodial "room and board" care which is not aimed at simultaneously providing active or therapeutic treatment leading to cure. *See supra* at 21-22; *Connecticut v. Schweiker,* 557 F. Supp. at 1084-85; *Woe v. Matthews,* 408 F. Supp. at 422, 426-29 & n.23.[26]

We conclude that the agency acted contrary to statutory provisions and congressional intent when, to identify the overall character of these three facilities as IMDs, it employed criteria chiefly focusing on the mere presence in each facility of patients with diagnoses of a mental disability. We hold that the cardinal gauge by which to distinguish IMDs and ICFs must be the degree of care and treatment required by the mental or physical conditions of patients residing at any given facility.[27] We thus hold that the Board's decision upholding the disallowance to the State was unsupported by substantial evidence on the record as a whole. We reverse the decision and remand

[26] The district court found that "by 'institution for mental diseases' the Congress intended to refer to those institutions which provided primarily long-term care for the mentally ill by administering psychiatric treatment for its residents on the premises." *Minnesota v. Schweiker,* No. 4-82-155, slip op. at 15 (D. Minn. Aug. 25, 1982).

The district court in *Connecticut v. Schweiker,* 557 F. Supp. at 1081 n.8, expressly disagreed with this characterization, finding that long-term care and psychiatric care are not necessary for a facility to be an IMD, but that "total care" is. That court defined "total care" to mean "the very high level of care given, for example, to a hospital inpatient or a nursing home resident. The patient is totally dependent on the institution and is submerged in it." *Id.* at 1081 n.9.

Cf. Schweiker v. Wilson, 450 U.S. at 233 n.17 ("the average inpatient stay in public mental hospitals is short"; the "rapidity with which inpatients are released from public institutions has increased since the 1950's").

[27] The degree of care and treatment *required* by a patient's mental or physical condition should be equivalent to the degree of care and treatment *furnished* to the patient by a facility. Emphasis on the degree of care and treatment required by patients in order to determine whether the overall character of a facility is that of an IMD should eliminate HHS' concern that a facility would be rewarded if the nature of its services did not sufficiently

(footnote continues)

to HHS. We do not reach the procedural issues raised by the State pertaining to the requirements of the Administrative Procedure Act, 5 U.S.C. § 552 *et seq.* (1982), that the guidelines employed must be published.

The district court is thus affirmed in part in its grant of summary judgment to the State and denial of summary judgment to HHS. The district court's order is vacated for lack of jurisdiction as to that portion of the order which requires that the Secretary shall return to the State the federal funds withheld pursuant to the disallowance.

The petition filed by the State of Minnesota (No.) for direct review of the agency's decision is dismissed for lack of jurisdiction.

A true copy.

ATTEST:

CLERK, U.S. COURT OF APPEALS,
EIGHTH CIRCUIT.

(footnote continued)

provide the level of care required by a patient's mental diagnosis. The statute requires that state plans for medical assistance provide for independent professional review of the need for intermediate care prior to admission in an ICF, and periodic review of the type and adequacy of care being provided, the necessity and desirability of continued ICF placement, and the feasibility of meeting a patients' [sic] need through alternative institutional or non-institutional services. 42 U.S.C. § 1396a(a)(31) (1976); 42 C.F.R. part 456 (1982); *see Colorado Department of Social Services v. Department of Health and Human Services*, 558 F. Supp. 337, 340-47, 348-55 (D. Colo. 1983). By disputing individual placement decisions, HHS can insure the equivalency of the degree of care and treatment rendered by a facility and the degree required by patients.

APPENDIX F

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS EASTERN DIVISION

No. 82 C 1349

STATE OF ILLINOIS, BY THE ILLINOIS DEPARTMENT OF PUBLIC AID,

Plaintiff,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES AND MARGARET HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

MEMORANDUM OPINION AND ORDER

SUSAN GETZENDANNER, *District Judge:*

This matter is before the court on defendant HHS's written objections to the report and recommendation dated September 27, 1983, submitted by Magistrate James T. Balog. (Attached as Appendix A.) The Magistrate recommended that the court grant plaintiff Illinois' motion for summary judgment and deny HHS's cross-motion for summary judgment. Upon its own de novo review of issues objected to, Fed.R.Civ.P. 72(b), the court accepts the Magistrate's recommendation. As indicated below, however, the court does not accept all of the Magistrate's reasoning. The following discussion assumes knowledge of the basic facts (and of the standard abbreviations), as set out in the Magistrate's report.

Interpreting the fundamental purpose of the statutory IMD exclusion is central to this dispute. The Magistrate correctly concluded that in excluding IMDs Congress intended to exclude certain types of institutions for people with mental diseases, in particular those providing traditional treatment and care of such persons. Congress did not intend to exclude all institutions providing care to people with mental diseases, and the Congressional plan seems to be to encourage the development of alternative care facilities for those with mental diseases. The definition of an IMD therefore must depend in large part on the type of care and treatment provided. Excessive reliance on the percentage of residents having a mental disease is inconsistent with Congressional intent and with the statutory scheme. The other courts that have reviewed the Board's disallowance decision all have reached this same conclusion concerning the IMD exclusion. *State of Minnesota* v. *Heckler,* 718 F.2d 853 (8th Cir. 1983), *aff'g in part and vacating in part State of Minnesota* v. *Schweiker,* No. 4-82-155 (D. Minn. Aug. 25, 1982); *State of Connecticut, Department of Income Maintenance* v. *Schweiker,* 557 F.Supp. 1077 (D. Conn. 1983).

In construing the statutory term IMD the Magistrate went beyond a determination that the definition of IMD must relate in large part to the type of treatment provided. The Magistrate concluded that the term IMD was intended to refer to institutions providing long-term care for the mentally ill by administering psychiatric treatment for residents on the premises. (Magistrate's report, p. 7.) This interpretation also was given by the district court in *Minnesota* v. *Schweiker.* In *Connecticut* v. *Schweiker* the court disagreed with this reading, and instead interpreted the term IMD as requiring "total care." 557 F.Supp. at 1081 & n.8. Illinois proposes another definition. Illinois would read the statutory term IMD as covering only state mental hospitals and their private equivalents. The court sees no reason to embrace any of these positions. The Magistrate did not have the benefit of the Eighth Circuit's decision in *Minnesota* v. *Heckler,* 718 F.2d 852, issued shortly after the Magistrate filed his report. In that case the Court concluded that "the paramount criterion for distinguishing an IMD from an ICF must be the degree of care

and treatment required by patients." *Id.* at 863. The Court did not, however, attempt to formulate a working definition of an IMD. This court believes the Eighth Circuit's approach to be correct.[1] The courts lack the expertise and resources necessary to set down precise definitions of the type attempted by the Minnesota and Connecticut district courts. To review the decision of the Grant Appeals Board, it is necessary only to recognize that the type of treatment provided must be accorded some significant weight in characterizing an institution as an IMD. The Board placed no weight at all on this consideration, and the court thus is required to set aside the Board's decision, no matter how, precisely, the question of treatment should be factored into the definition of an IMD.

Congress has not defined the term IMD, but HHS has:

> "Institution for mental diseases" means an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

42 C.F.R. § 435.1009(e) (1982). This regulatory definition suggests an emphasis on the counting of "persons with mental diseases," but the definition's reference to "overall character" arguably contemplates consideration of factors other than the composition of the resident population. The Board in fact understood "overall character" in this way. The Board stated:

> As stated above, the Agency was reasonable in looking to patient population as a factor in determining the "overall character" of a facility.

---

[1] By embracing the approach taken by the Eighth Circuit, the court does not intend to hold that the categories of IMD and ICF are mutually exclusive, as the quoted passage may seem to suggest.

• • •

> For the Agency to take some risk of misclassification [in counting residents with a mental disease] was reasonable, where the patient population was not the sole basis for determining "overall character."
>
> • • •
>
> This concern [with a hypothetical shift in population from just below to just above the 50% guideline] is irrelevant here, however, given the high percentages of mentally ill in most of the facilities during the disallowance periods and since other significant factors also evidenced "overall character" of the facilities as IMDs.

(Decision, pp. 33-34.) In this court, too, HHS purports to rely on a broad range of factors. HHS describes the composition of the resident population as merely a "logical, important factor in determining the nature of an institution." (HHS memo in support of summary judgment, p. 36.) HHS maintains that it never relied on any single criterion in characterizing facilities as IMDs. (HHS memo in support of summary judgment, p. 40.)

Despite these disavowals of patient-counting as the sole basis for characterizing a facility as an IMD, the HCFA's Guidelines and the Board's review in effect relied almost exclusively on the percentage of residents within a facility that had a mental disease. The HCFA report stated:

> Eight criteria have been set forth as the basis for a determination that a facility is an institution for mental diseases. Field Staff Information and Instruction Series (FSIIS) 76-44 dated November 7, 1975, . . . specifies that an institution is characterized as "primarily" one for mental diseases if:
>
> 1) It is licensed as such;
>
> 2) It is advertised as such; or
>
> 3) If more than 50 per cent of the patients have a diagnosis of mental disease, as defined in the *International Classification of Diseases*, Eighth Revision . . . .

> The following five additional criteria are outlined in FSIIS 76-97 dated May 3, 1976 . . . FSIIS 76-156 dated September 14, 1976 . . . and Health, Education and Welfare Region IX legal opinion dated October 28, 1977 . . . as further support for a determination that a facility is an institution for mental diseases:
>
> [4] Used by mental hospitals for alternative care;
>
> [5] Patients who were accepted directly from the community but had been in mental hospitals;
>
> [6] Proximity to State mental institutions (25 mile radius);
>
> [7] Age distribution uncharacteristic of nursing home patients;
>
> [8] Basis of Medicaid eligibility for patients under age 65 due to mental disability.
>
> FSIIS 76-156 also defines a mental patient as one "with mental disability necessitating nursing home care who has no significant physical problems," or a " . . . Patient with physical problems that would not independently necessitate nursing home care, but who has a mental disability that would preclude his proper handling of his physical problem outside a nursing home . . . ."

(HCFA report dated March 5, 1979, pp. 2-3.)[2]

Only three of these criteria do not relate to counting or estimating the number of patients with a mental disease. Of these three criteria, two were not met in the case of any ICF in question here, and the third criterion, met in every case, is of virtually no probative value. The court has found no indication in the record that any of the facilities was licensed as an IMD, as in Guideline 1). The HCFA report found that no facility was advertised as an IMD, as in Guideline 2). All nine facilities

---

[2] The parties have disputed whether these guidelines should have been published. The court finds it unnecessary to address this question.

met Guideline 6), but this Guideline is almost useless. According to HHS, this Guideline "was useful because, in the process of deinstitutionalization of mental patients, many States established smaller institutions such as SNFs on the grounds or in the immediate vicinity of State mental hospitals." (HHS memo in support of summary judgment, p. 32.) A 25-mile proximity test, at least as applied in an urban area like Chicago, does nothing to determine whether a facility is merely ancillary to an IMD. There are IMDs in Chicago, and almost all ICFs in or near Chicago are within 25 miles of these IMDs. Five of the nine ICFs in question here are within the city limits of Chicago, and two more are in Evanston, which borders on Chicago. It is not clear whether the 25-mile test has any probative value as applied to the Chateau Waukegan, in Waukegan, or the Kankakee Terrace, in Bourbannois.

The five remaining criteria all are ways of determining the number or percentage of residents with a mental disease. Guideline 3) explicitly involves the counting of residents.[3] Guideline 7) obviously is another way of determining how many patients have a mental disease. The assumption apparently is that younger residents are likely to be in a facility because they have a mental disease. To the extent this assumption is not accurate, then the probative value of the test is weakened, because the test also would be counting younger residents with only physical disabilities. Guideline 8) clearly is a way of identifying residents with a mental disease.

Guidelines 4) and 5) do not necessarily relate only to the counting of patients. It seems that these Guidelines conceivably could be applied in a way that would help determine the type of treatment provided by a facility. If many residents came to a facility directly or indirectly from an IMD, the facility possibly might be providing IMD-type treatment. The Board found that Illinois was not "dumping" patients from mental hospitals into ICFs, as a state conceivably could do in order to collect FFP.

[3] The accuracy of HCFA's counting of patients has been disputed hotly, both before the Board and in this court. The court finds it unnecessary to address this dispute.

Nonetheless, the Board found that the number of direct transfers into these facilities supported the conclusion that they were IMDs. The court has studied the HCFA report and page 42 of the Board's decision, discussing residents transferred from mental hospitals, and the court concludes that Guidelines 4) and 5), in their actual application, amounted to little more than another way of counting or estimating how many residents had a mental disease.

In addition to using these Guidelines, the HCFA also attempted to get a sense of how each institution viewed itself and how it was viewed by state authorities and others.[4] The HCFA thus collected several statements to the effect that these ICFs served primarily mental health patients, which again merely reflects the composition of the resident population. The HCFA report does quote a few statements regarding the type of care given in some ICFs, particularly the Traemour Home. Where the HCFA does refer to the type of care given, the care generally seems oriented toward helping patients learn to function in everyday life. In the Traemour Home, residents take public transportation to shopping areas, attend workshops in the community, learn about current events and communication skills, and have a glamour clinic and a weight watching program; these residents are allowed to leave any time they wish, including overnight absences. The HCFA report does not discuss the nature or purpose of such treatment, and the court's impression is that the HCFA describes the treatment only for the purpose of confirming that most residents indeed have a mental disease. The court lacks HHS's administrative expertise in evaluating care and treatment, but it appears to the court that

[4] The court notes that the HFCA report includes this passage:

> A newspaper article published on October 24, 1978, in the Waukegan News Sun related the following on the character of Chateau Waukegan: "It has become a halfway house for discharged mental patients. It is a place for mentally unbalanced people. Downtown Waukegan was not meant to be a rehabilitation center for mental patients." (HCFA audit report dated March 5, 1979, p. 11.) The HCFA's apparent reliance on this material does not encourage deference to its determination. The Board did not comment specifically on this passage, noting only that the HCFA had examined newspaper articles. (Decision, p. 40.)

some of the treatment at the Traemour Home, for instance, referring residents to community agencies for "work preparation," is the type that would not predominate at an IMD, as Congress intended that term to be applied.

The Board did not discuss each guideline separately, but it found that the HCFA reasonably could have relied on the guidelines as a group. (Decision, p. 34.) The Board also discussed some other factors respecting the Illinois facilities. There was no discussion of the type of treatment given in the facilities, except that the Board observed that "while the [Grasmere Residential] Home did not provide 'mental treatment,' it did consider itself as providing some form of treatment to patients where therapeutically indicated." (Decision, p. 41.) The Board also discussed the role of the Illinois Department of Mental Health and Developmental Disabilities, noting that the Department had follow-up responsibilities for persons transferred from hospitals into ICFs. While some probative argument possibly could be based on the Department's role, the Board discounted its importance; however, the Board stated: "we nonetheless consider it some support for the general finding that high percentages of the patients were mentally ill." (Decision, p. 42.) Concluding its discussion of the Illinois facilities, the Board Stated:

> Thus, while we find Illinois' evidence sufficient to establish certain facts, those facts are not directly relevant to the issues before us and do not overcome the Agency's finding that high percentages of the patients in the facilities had mental disorders and that the State in some way recognized that the facilities were primarily serving the mentally ill. Thus, we conclude that the facilities met the regulatory definition and were IMDs.

(Decision, p. 42.) It is beyond dispute that the Board relied almost exclusively on the percentage of residents in each facility having a mental disease, giving little or no consideration to the kind of treatment provided. In fact, HHS argues in this court that the provision of *any* kind of treatment to patients with a mental disease should contribute to a finding that a facility is an

IMD. (HHS memo in support of summary judgment, p. 39.) While the use of several guidelines and the phrase "overall character" may give a different appearance, the Board's decision gave no significant weight to any factor other than the composition of the resident population.

HHS argues that its intrepretation of the statutory exclusion is entitled to deference, as the interpretation of the agency charged with implementing the statute. The court in the Connecticut case discussed this question at length and concluded that such deference would not be appropriate. 557 F.Supp. at 1089-91. The Eighth Circuit, without extensive discussion, indicated that HHS's interpretation could not control. 715 F.2d at 865. This court too deems it inappropriate to defer to HHS's position. At issue here is the fundamental purpose of the IMD exclusion. Either the exclusion was intended to deny FFP for facilities treating primarily people with a mental disease, or it was intended to deny FFP for a broad class of institutions treating such people, while still offering FFP for alternative treatment facilities. Agency expertise would not be particularly useful in deciding this question of statutory construction. Further, as the court has noted, the Board itself indicated that it understood the regulatory phrase "overall character" as comprehending factors other than merely the composition of the resident population, even though its determination in fact did not incorporate other factors. It is not clear that HHS has a single well-defined interpretation of the IMD exclusion, so deference is particularly inappropriate.

As the Eighth Circuit and the district court in Connecticut held, the Board used criteria fundamentally incompatible with the purpose of the IMD exclusion in characterizing the ICFs here as IMDs. The Board's decision therefore was not in accordance with law, and the court holds the Board's decision to be unlawful and sets it aside. 5 U.S.C. §706(2)(A).[5]

---

[5] The Eighth Circuit set aside the Board's decision on the stated basis that it was unsupported by substantial evidence on the record as a whole. 718 F.2d at 866. Illinois has not argued for this standard of review, which applies to record review of an agency hearing provided by statute. 5 U.S.C. § 706(2)(E). It is not clear to the court that the hearing before the Board, under 45 C.F.R. Pt. 16 (1983), was such a hearing.

A final question to be considered is the scope of relief available to Illinois. Paragraph A of Illinois' prayer for relief seeks a declaratory judgment setting aside the Board's decision, and such relief clearly is available and will be ordered. Paragraphs B and C request relief which may not be available. First, the requested injunction may be broader than appropriate. The court sets aside the Board's decision, but the court does not hold that the facilities in question are not IMDs. HHS is free to undertake another review using standards consistent with Congressional intent. Second, and more important, it is not clear to the court whether paragraphs B and C in effect request money damages. The Eighth Circuit expressly held that jurisdiction to award such relief lies exclusively in the U.S. Claims Court. 718 F.2d at 857-860. Illinois shall file a statement within 21 days, either dropping its request for further relief (beyond a declaratory judgment setting side the Board's decision), or setting forth a schedule, agreed upon by the parties, for briefing the availability of the other relief requested.

Accordingly, the court accepts the recommendation of the Magistrate. Illinois' motion for summary judgment is granted, and HHS's motion for summary judgment is denied. The court holds that Decision No, 231 of the Grant Appeals Board was not in accordance with law and should be set aside. Illinois is to file a statement concerning relief within 21 days of the entry of this order.

It is so ordered.

SUSAN GETZENDANNER
United States District Judge

March 20, 1984

APPENDIX A

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS EASTERN DIVISION

NO. 82 C 1349

STATE OF ILLINOIS,
BY THE ILLINOIS DEPARTMENT OF PUBLIC AID,
Plaintiff,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES AND MARGARET HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES,
Defendants.

TO: HONORABLE SUSAN GETZENDANNER, *JUDGE UNITED STATES DISTRICT COURT*

HONORABLE JUDGE:

REPORT AND RECOMMENDATION
of Magistrate James T. Balog

I. INTRODUCTION

This matter comes before this Court on the parties' cross-motions for summary judgment. The Plaintiff, the State of Illinois (Illinois), has filed this action for declaratory and injunctive relief against the implementation of Decision No. 231 of the Departmental Grant Appeals Board of the Department of HHS (HHS). Illinois asserts jurisdiction under 28 U.S.C. §§ 1331, 1361, and 2201. Further, Illinois claims that judicial review of the Board's decision is authorized by 5 U.S.C. §§ 701-706.

Under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, Illinois received payments from HHS to cover a percentage of the costs incurred in providing various types of medical assistance to the needy, including institutional services in intermediate care facilities (ICFs). These payments are called federal financial participation (FFP). From October 1, 1976, through September 30, 1978, numerous facilities within Illinois were certified as ICFs and thereby eligible for FFP under the Act. Among these facilities were the nine facilities involved in the case at bar.[1] During the aforementioned time-period, Illinois claimed and received FFP for expenditures it made in connection with the services rendered to the Medicaid-eligible residents of the nine ICFs. On March 5, 1979, the Health Care Financing Administration (HCFA) of HHS issued an audit report. ("Report on Review of Institutions for Mental Diseases Under the Medicaid Program" attached as 'Exhibit A' to Brief in Support of Defendants' Cross-Motion for Summary Judgment and In Opposition to Plaintiff's Motion for Summary Judgment [hereinafter cited as HCFA Audit Report].) This report concluded that the nine facilities were not really ICFs, but rather "institutions for mental diseases" (IMDs), and that the services rendered to the residents of these nine facilities were ineligible for FFP under the Medicaid program. HHS then moved to disallow all FFP for expenditures made by Illinois during the 1976-1978 period; this entailed the recoupment of $4,261,162.00 paid to Illinois. Illinois applied to the Departmental Grant Appeals Board (Board) for review of the disallowance decision. After having consolidated Illinois' application with those of California, Connecticut, and Minnesota, the Board issued Decision No. 231 upholding the retroactive disallowance by the HCFA of the FFP paid to Illinois for the services provided to the residents of the nine facilities. Having exhausted all of its administrative remedies, Illinois filed this cause of action.

[1] The nine facilities are the Clayton Residential Home, the Grasmere Residential Home, the Traemour House, the Pembridge House, the Chateau Waukegan, the Central Plaza, the Stratford Home, the Evanston-Ridgeview, and the Kankakee Terrace.

II. JURISDICTION

Some confusion occurred as to the proper forum for this action. In addition to filing the instant suit in the District Court, Illinois petitioned the Court of Appeals for the Seventh Circuit to review the decision of disallowance. The Seventh Circuit held that the District Court possesses jurisdiction to review this disallowance. *Illinois* v. *Schweiker*, Nos. 82-1175 and 82-1752 (7th Cir. May 6, 1983). Thus, this Court may properly hear this suit. *See Minnesota* v. *Schweiker*, Civil No. 4-82-155 (D. Minn. Aug. 15, 1982); *Connecticut* v. *Schweiker*, Civil No. H-82-146 (D. Conn. Feb. 17, 1983).

III. STANDARD OF REVIEW

This action seeks judicial review of a final administrative decision. The Administrative Procedure Act, 5 U.S.C. § 706,[2] limits the extent of this Court's reviewing authority. In examining this statute's restrictions, the Supreme Court has

[2] 5 U.S.C. §706 provides:

> To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall—
>
> (1) compel agency action unlawfully withheld or unreasonably delayed; and
>
> (2) hold unlawful and set aside agency action, findings, and conclusions found to be
>
> (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;
>
> (B) contrary to constitutional right, power, privilege, or immunity;
>
> (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;
>
> (D) without observance of procedure required by law;
>
> (E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or
>
> (F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.
>
> In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

focused in on two key questions to be asked by the reviewing court: (1) whether the agency acted within the scope of its authority and (2) whether the agency's decision was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. *Citizens To Preserve Overton Park, Inc.* v. *Volpe*, 401 U.S. 402, 415-416 (1971). The first question entails an analysis of the agency's action vis-a-vis the legislation defining its jurisdiction. As to the second question, "the court must consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Id.* at 416. Where the agency's action involves the interpretation of a statute which it administers, that interpretation generally deserves deference. *Schweiker* v. *Gray Panthers*, 453 U.S. 34 (1981). However, the extent of that deference depends upon "the nature of the agency's interpretation. Unofficial and unpublished agency interpretations are not given the same deference as more official pronouncements." *Minnesota* v. *Schweiker, supra*, slip op. at 6, citing *Morton* v. *Ruiz*, 415 U.S. 199 (1974). With these principals stated, this Court will now examine the statute involved in this suit.

IV. STATUTORY AND REGULATORY SCHEME

42 U.S.C. § 1396b provides that HHS shall pay to each State, which has a plan approved under 42 U.S.C. § 1396a, "an amount equal to the Federal medical assistance percentage . . . of the total amount expended . . . as medical assistance under the State plan. . . ." The statute defines "medical assistance" to include inpatient hospital services, skilled nursing facility (SNF) services, and intermediate care facility (ICF) services unless those services are performed in an institution for mental diseases (IMD). 42 U.S.C. § 1396d(a). Such services, when performed in an IMD, are the exclusive responsibility of the State. While the statute defines what constitutes an ICF,[3] it is silent as to an IMD. By regulation, HHS has defined an IMD.

[3] The term "intermediate care facility" refers to:

> an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or

(footnote continues)

> "Institution for mental diseases" means an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

42 C.F.R. § 435.1009 (1982). In spite of this definition, the parties dispute that which Congress intended by the term "IMD". Illinois argues that the term "IMD" encompasses only state mental hospitals or their private equivalents. (Brief in

(footnote continued)

> skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, (2) meets such standards prescribed by the Secretary as he finds appropriate for the proper provision of such care, (3) meets such standards of safety and sanitation as are established under regulation of the Secretary in addition to those applicable to nursing facilities under State law, and (4) meets the requirements of section 1395x(j)(14) of this title with respect to protection of patients' personal funds. The term "intermediate care facility' also includes any skilled nursing facility or hospital which meets the requirements of the preceding sentence. The term "intermediate care facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to institutional services deemed appropriate by the State. The term "intermediate care facility" also includes any institution which is located in a State or an Indian reservation and is certified by the Secretary as meeting the requirements of clauses (2), (3), and (4) of this subsection and providing the care and services required under clause (1). With respect to services furnished to individuals under age 65, the term "intermediate care facility" shall not include, except as provided in subsection (d) of this section, any public institution or distinct part thereof for mental diseases or mental defects.

42 U.S.C. § 1396d(c).

Support of Plaintiff's Motion for Summary Judgment, pp. 22-36.) Because the nine facilities in question are not (and never were) state mental hospitals or their private equivalents, Illinois concludes that they cannot be classified as IMDs. HHS contends that the term "IMD" is sufficiently broad to subsume hospitals, SNFs, and ICFs. (Brief in Support of Defendants' Cross-Motion for Summary Judgment and In Opposition to Plaintiff's Motion for Summary Judgment, pp. 16-26.)

After conducting its own independent review of the statute, the relevant legislative history, and the pertinent case-law, this Court concludes that Congress intended the term 'institution for mental diseases' "to refer to those institutions which [provide] long-term care for the mentally ill by administering psychiatric treatment for its residents on the premises." *Minnesota* v. *Schweiker, supra,* slip op. at 15. This conclusion focuses upon the nature and degree of care provided by the facility in question. It finds support in the case of *Legion* v. *Richardson,* 354 F.Supp. 456 (S.D.N.Y.), *aff'd sub nom. Legion* v. *Weinberger,* 414 U.S. 1058 (1973). The *Legion* court upheld the Medicaid statute against an equal protection claim, stating that the statute "distinguishes between medically indigent persons who require short-term care and those who require long-term care." *Id.* at 459. The *Legion* court discovered in the legislative history the intent of Congress to leave the responsibility for long-term care of patients in public mental institutions with the States. *See* S.Rep. No. 404, 89th Cong., 1st Sess., 144, *reprinted in* [1965] U.S. Code Cong. & Adm. News 2084. *See also* 117 Cong. Rec. 44721 (1971) (remarks of Sen. Long). Thus, the determination of whether or not a facility is an IMD centers upon the nature and extent of services being performed in the facility.

V. HHS' ACTION IN THIS CASE

In November of 1978, the Medicaid Regional Office of the HCFA undertook a review to determine whether any facilities certified as SNFs or ICFs met the definition of an IMD. In performing this review, the Medicaid Regional Office relied on

three documents which comprise part of the Field Staff Information and Instruction Series (FSIIS). These three documents set out eight criteria that form "the basis for a determination that a facility is an institution for mental diseases." (HCFA Audit Report, p. 2.) These criteria are as follows:

> (1) It is licensed as such;
>
> (2) It is advertised as such; or
>
> (3) If more than 50 per cent of the patients have a diagnosis of mental disease, as defined in the *International Classification of Diseases,* Eighth Revision (codes used from this Source Document are given in Attachment 4);
>
> (4) Used by mental hospitals for alternative care;
>
> (5) Patients who were accepted directly from the community but had been in mental hospitals;
>
> (6) Proximity to State mental institutions (25 mile radius);
>
> (7) Age distribution uncharacteristic of nursing home patients;
>
> (8) Basis of Medicaid eligibility for patients under age 65 due to mental disability.

(HCFA Audit Report, pp. 2-3.) With these criteria in hand, personnel from the Medicaid Regional Office began contacting the Illinois Department of Mental Health and Developmental Disabilities (IDMH/DD), the Illinois Department of Public Aid (IDPA), and the Illinois Department of Public Health (IDPH) to gather information concerning nursing homes used for placement of the mentally ill. Preliminary findings revealed that twenty facilities potentially met the definition of an IMD. Further review of records resulted in the identification of eleven facilities as probable IMDs. The next step of the audit process entailed two employees of the Medicaid Regional Office, neither of whom were medical personnel, examining the medical review, the independent professional review, and the utilization review documents for each Medicaid patient at each facility. These documents included the diagnosis and treatment as recorded in each patient's medical record. (HCFA Audit

Report, p. 5.) Where the primary reason given for a patient's institutionalization was a mental dysfunction, the Medicaid Regional Office considered the patient to be mentally ill. Then, based on the eight criteria noted above, the Medicaid Regional Office found nine of the facilities to be IMDs. (HCFA Audit Report, p. 6.)

VI. DISCUSSION

The review made by the Medicaid Regional Office and resulting in the HCFA Audit Report directed its attention toward the diagnosis of the individuals in the nine facilities. This analysis almost completely ignored the type of services rendered by the facilities in question. As to eight of the nine facilities in question, the HCFA Audit Report merely states that "the primary nature of care rendered ... is geared toward [individuals/patients] with mental illnesses." (HCFA Audit Report, pp. 7-18.) Of these eight facilities, the Report delves no deeper into the services rendered by five. As to the remining three facilities, the Report gives superficial treatment to the type of service rendered: *e.g.*, vocational rehabilitation services, community workshop program, and counselling services. The Report states nothing about long-term care of the administration of psychiatric treatment. This action—the determination on the basis of diagnosis that the nine facilities are IMDs—by HHS disregards the statute and the caselaw interpreting the statute. As such, this action is both arbitrary and capricious; it does "not square with Congress' understanding of the statute," and "conflicts with the Medicaid philosophy of nondiscrimination on the basis of diagnosis, as well as with HHS' policy of encouraging deinstitutionalization." *Minnesota* v. *Schweiker, supra,* slip op. at 15.

VII. CONCLUSION

For the reasons stated herein, IT IS RECOMMENDED that the Plaintiff's Motion for Summary Judgment be GRANTED and that the Defendants' Cross-Motion for Summary Judgment be DENIED.

Respectfully submitted,

JAMES T. BALOG
United States Magistrate

DATE: SEPTEMBER 27, 1983.

The parties may serve and file written objections to this Report and Recommendation within ten (10) days.

Copies have, this date, been mailed to:

ELLIN P. BREWIN
Special Asst. Attorney General
130 North Franklin Street
Suite 300
Chicago, Illinois 60606
Attorney for Plaintiff

DAN K. WEBB
United States Attorney
219 South Dearborn Street
Chicago, Illinois
ATTN: JAMES J. KUBIK
Asst. United States Attorney
Attorney for Defendants.